			1 For State	State of Marylar	d / Depa	artment of Horificate of D	ealth and N	Mental Hy	giene	2005	03001
		٠.	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	-	3. Time of Death
	Physici /Medio		Charles Flo	yd Coffin				Februa	ry	, 2005	6:45A ™
	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or			4c. 0	County of Death	
			6642 Walnut Wo		last highday	Baltin	If Under 24 Hrs.	R Date of Birt	h	Baltin	
L	Funeral Director		144-12-3806 Usual Residence of Decedent	DM 2□F 86	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Date October	7, Year) 23,19		place (State or Foreign ntry) Jersey
	Aaryland f ehow	ō	10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2☐XNo
	with the Pa or 28a-	i Director	Maryland Baltimo 10e. Street and Number 6642 Walnut Wood		ltimor	101. Zip Code 212	212		10g. Citiz	en of What Cou USA	intry?
336	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Itame 23a or 28a-f ehow The Medical Examinar must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? XXYes 2 □ No WW If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp., Mexican, Puerto	pecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify:	
Maryland 21215-0036	within 72 houene. than nature	Completed	15. Decedent's E. (Specify only highest gra		(Give	dent's Usual Occupa kind of work done di DO NDT use retired)	uring most of worl	king		d of Business/Ir	
21	filed wit Hygien other the	Con		4	Ow	ner		450		nufactu	ring
/land	B la	To Be	17. Father's Name (First, Middle, Last, Charles William F					roudfoo	t		
	d 2 sho th and 7 Is m traum	9 8	19a. Informant's Name/Relationship (Margaret C Widman	Type, Print) DTR		ng Address (Street a VESWOOD La					
ore,	es 1 an of Heall f Item 2 r other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	1 /	Place of Disponentery, cre-	osition (Name of matory or other place		Date	20c. Loc	ation - City or T	own, State
Ë	artment of ortant: If it injury or o		4 □ Donation 5 □ Other (Specif	Bro		e Cemetery					ew Jersey
Baltimore,	pernit. Pages Department of I Important: If It any injury or o		21 Agnature of Funeral Service Licer	lan Kenak	25	2. Name and Address	s of Facility Mit 100 York Ro				
	Pnysician /Medical		23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. Due to (or as a consequence)	nar	ter the mode of dying Thror	n, such as cardiac	1 1	is n	n	Approximate Interval Between Onset and Death
3760,	Examile be executed a sician and e burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq c. Due to (or as a conseq d.	y) O Y uence of):	na of	- Pri	ostat	e.		p deans
.O. Box 68	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)			23	3d. Date of deliv	rery Day Year
<u>α</u>	uires that n signed b	by	Part II. Other significant conditions of	ontributing to death but not res	_	- 0	n in Part I.	23e. Did to			the cause of death?
Records,	0 5 0	Completed						24a. Was autop	sy		opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea				
<u>></u>	Physician: this certificanal director,	To	1 ☐ Yes 2 ☑ No		ER/Outpatier		4 Nursing ric	ome 5 Aesid			<i>fy</i>)
Division of	Attending P r death. ector: After to by the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time o Injury	Work	at ? ′es 2 □ No	28d. Describe h	iow injury	occurred	
Divis	s after de safter de al Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	reet, factory, office		28f. Location (S City or Tow		Number or Rur	al Route Number,
	To the Hospital or Attending 6 within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical (ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	within 2 To the	Z	29b. Signature and title of certifier	101		29c. License	number		29d. Date	signed (Month,	Day, Year)
	10		Marzlu.	Dalen	•	DI	8170		02/	01/20	205
	10		30. Name and address of person who	completed cause of death (Item	838 (Type,	Print) EENE 17	ree Rai	Pik	esvi.	lle Me	05 1 21208
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Signa	ture de	parties)			

			1 - For State Registrar	State of Ma	aryland		artment of rtificate of				Reg. No	105	03002
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, L	COOK ive street and number)		, /	4b. City, Town,	or Location	n of Death	2. Date of De Month	25 S	Year-	2 = 1
	Funeral Director			Sex 7. Ag	9) 1 e (in yrs. ia 74	Yrs.	If Under 1 Yea Months Day		er 24 Hrs.	8. Date of Bir Month, Da 09-15-15	th gy Year)	9. Birth	place (State or Foreign into) Carolina
	72 hours after death with the Maryland naturel', or items 23a or 28e-f ehow dical Exaciliyer; ust be notified at	ector	10a. State 10b. County MD NA 10e. Street and Number			Town or Lo					10g. Citizen		10d. Inside City Limits 1 XYes 2 □ No
	death with Tis 23a or 3	Funeral Director	912 N. Arlington Ave	12. Was Decedent	Ever in U.S	i. 13.	21217 Was Decedent of If Yes, specify Cu		Origin? (Spe	cify Yes or No		USA Race - Ameri	
9800	nours after o urei', or iter L'Exercitiver	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	No		1□Yes 2ሺN	Specif		Rićan, etc.)	Spe		ack
21215-0036	- 2 B	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12	Education rade completed) College (1-4or 5	5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii Driver	e durina me	ost of worki	ng		f Business/Ir	idustry
Maryland	should be filed within and Mental Hygiene. s marked other then umatic event, Le M	To Be C	17. Father's Name (First, Middle, Las Noah E. Cook Sr.						M	(First, Middle artha A	shford		
	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship Sharon J. Cook-Let 20a. Method of Disposition	· · · ·	20b. Pla	ace of Dispo	420 N. De sition (Name of	enison	St. BA			.9	
Baltimore,	permit. Pages Department of i importent: If it any injury or o		1 N Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Service Lice)	eify)	1	g Memor	ial PArk Name and Add	ress of Fac				11stown	
			23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	polications that caused one cause on each lin	I the death.							timore,	Approximate Interval Between Onset and Death
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	licai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as	a conseque	sele ence or,	ste	Hea	t 7	Deser.	c.01	o p	years acute Exocutati
P.O. Box 6	that the death certifics ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal c	death 3	Ectopic pregnan Other (specify)				23d. [Date of deliv Month	
	w requires that the by been signed by should be detact	by	Part II. Other significant conditions	contributing to death b		-	nderlying cause g	iven in Par	t I.		obacco use co Yes 2□No		he cause of death?
Division of Vital Records,	The ate ha	Completed								1 Yes	osy rmed? 2 XNo	prior to co death?	opsy findings available impletion of cause of
n of Vit	Phys this ral di	on: To Be	25. Was case referred to medical examiner? 1 22 9 2 No 27. Manner of Death 1 25 Vatural 5 Pending	Hospital: 1 Inpatie	v 2	R/Outpatien 28b. Time of Injury	28c. Inp	then 40	Nursing Hon	(Check only one 5 Resided Resided Resided Resided Rescribed Reserved Resided Reserved Resided	dence 6 🗆 C		ý)
Divisio	or Attenditer death	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be One Blace of Jair				Yes 2[8f. Location (\$ City or Tox		mber or Rura	al Route Number,
	To the Hospitel or At within 24 hours effer or To the Funerel Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying F 2 Medical Example	Phyaician: To the best of miner: On the basis of and manner sta	examination	ledge, death on and/or inv	n occurred at the vestigation, in my	time, date a opinion, de	and place, a eath occurre	nd due to the d at the time,	cause(s) and i date and place	manner as s e, and due to	tated. the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier Salvator	e Raiti A	40			12			29d. Date sign バカス		
	8		30. Name and address of person who SALVATO RE RAIT					2	000 6	V. BAC	-T(M 0	RESE	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3	32. Registra 2005	r's Signatu	Mr.	Snorth s					Bale	Temore My

				For State Registrar	licuoo				d / Dep		nt of H	lealth a	and M	lental Hy		ne 0 (05	03003
				1. Decedent's Name (First	, Middle, La	ist)								2. Date of Do Month		Day	Year	3. Time of Death
		Physici /Medio		Dorsey			Μ.	•		C	raw	ford		Janua	ry	^{Day} 29	2005	10:50a [№]
5	}	Examir		4a. Facility Name (If not in:	-					1		r Location (4c. Count	y of Death	
र्				Joseph Ri	chey	Hospi						more						
50		Funeral Director		5. Social Security Number 238–18–053	4	Sex XXM 2□F	7. Ag	84	last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D. 03 3	rth ay, Ye	^{ar)} 20	9. Birthpl Count	ace (State or Foreign try) VC
~		and		Usual Residence of Deced 10a. State 10b. 0	County			10c. Cit	y, Town or L	ocation					_		10	Od. Inside City Limits
)		Manyl f sho	0	MD	NA			Ва	ltimo	ore								1 X Yes 2 □ No
		28a	Je C	10e. Street and Number						10f. Zip	Code				10g.	Citizen of	What Count	try?
3		death with the Maryland ms 23s or 28s-f show rmust be notified at	Funeral Director	3619 Park	Heia	hts Av	e				21	215				U.	S.A.	
•		death ms 2	Jera	11. Marital Status		12. Was Dec	edent	Ever in U	.S. 13	Was Dece	dent of H	ispanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - America	
~	9	ours after death with the Marylar rat', or items 23a or 28a-1 show Examiner must be notified at		1 Never Married 2	☐ Married	1 X Yes	2 0	No		1 ☐ Yes		Specify:		nican, etc./		Specia	ack, White, e	
0	5-0036	72 hours after natural', or ite	d by	3 ☑ Widowed 4 □ Di	ivorced	Year or E							·				1	Black
1	5	72 hours "natural",	Completed	15. Do (Specify only	ecedent's E highest gr	ducation ade completed)			16a. Dec	edent's Usu e <i>kind of wo</i> DO NOT u	al Occup	ation during mos	st of work	ing	16b	. Kind of E	Business/Ind	ustry
5	121	within ene.	m d	Elementary/Secondary (9th grade	(0-12)	College (na	1-4or 5	i+)	me.	Prin		4)			F	eder	al Go	overnment
7	d 21	be filed within tal Hygiene. Id other than	ပို	17. Father's Name (First, I	Viddle, Last							18. Mothe	er's Name	e (First, Middle				
-	an	Mental Mental arked o	To Be	Marcellus	Craw	ford						Lola	God	odman				
	Maryland	s 1 and 2 should be filed within Health and Mental Hygiene. Health and State of the Talenthan tem 27 is marked other than other traumatic event, the M	-	19a. Informant's Name/Re	elationship ((Type, Print)			19b. Mai	ling Address	s (Street	and Numbe	er or Run	al Route Numb	oer, Cit	y or Town	, State, Zip	Code)
0		and 2 salth a n 27 is		James Craw	ford	-Son			3619) Par	k H	eigh	ts A	Ave, B	al	timo	re, N	4d 21215
RE	ore,	ss 1 a of Hear Item		20a. Method of Disposition		70	Cana	20b. F	Place of Disp emetery, cre	osition (Na matory or o	me of other plac	(a)	7	Date	20c.	. Location	- City or To	wn, State
0	Ē	Page nent ant: M		1XX urial 2 ☐ Cren 14 ☐ Donation 5 ☐ O			State	Ga	rrisc	on Fo	res	t Ve	t. 2	2/7/05	(Owin	gs Mi	ills, Md
3	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral	ervice Lice	nsee	9	me		2. Name a Tarch 1300	Wab	ss of Facilit H We ash	st Ave,	Balt	im	ore,	Md	21215
9		Physician		23a. Part1. Enter the dise shock, or head failur Immediate Cause (Final	ase, or com re. List only	one cause on		,		0/	de of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death
		/Medical Examiner		disease or condition resulting in death)	(a		a conseq	uence of):	00	u	ny L	/ .	eleste	وستشيار		(4)	neglar
			iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, te	b. Due to	(or as	a conseq	uence of):	- 41	ord	eli					l l	750
2	> '092	te be executed ysicien and te burial-transit	i Examiner	that initiated events resulting in death) Last	Ì	c Due to	(or as	a conseq	uence of):									
3	687	3 × 5	dicai		•	d												<u> </u>
+		eath certifica attending ph for use as th	/Me	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, ou										23d. Da	ate of deliver	γ
in	P.O. Box	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	in the past 12 month. 1 Yes 2 No 9 Unknown		1□Live I 4□Pregi 9□Unkp	nant at			□Ectopic p □ Other (s _i								Day Year
2	s, P	es that igned b be deta	oy P	Part II. Other significent of	conditions	contributing to d	leath b	ut not res	ulting in the	underlying o	cause giv	en in Part I						e cause of death?
0		v require been sig should b												10	Yes	2 🗆 No	3 Proba	ably 4 DUnknown
7	Record	The law rate has be page 2 sh	Completed								-			24a. Was auto perfe 1 \(\text{Yes} \)	psy ormed	?	prior to com death?	sy findings available apletion of cause of 2 No
5	ita	riclan: Th certificate rector, pag	Bec	25. Was case referred to examiner?	medical								e of Deatl	(Check only	оле)			
S) t	Physicle this cert ral direct	To I	1 ☐ Yes 2 ☑ No		1	,		ER/Outpatie			4 🗀 140		me 5 Res				Hostie
2	ivision of Vital	offer		27. Manner of Death 1 ☑Natural 5 □	Pending	28a. Date (Mon	of Inju th, Da	ry y Year)	28b. Time Injury		28c. Injur Worl			28d. Describe	how ir	njury occui	rred	
\circ	Sio	death. ctor: A y the fu	cati	2 Accident 3 Suicide 6 S	Could not b		(1.1			M		Yes 2 🗆		Of Leastion	/Ctmot	and Alum	bor or Buml	Route Number,
(ΟĬ	or All after of Direction by	Certification:	4 Homicide	determined	209. Place	ling, et	c. (Specif	ome, farm, s y)	treet, factor	у, опісе			City or To			Dei OI HUIGI	Houte Number,
	_	To the Hospital or Attanc within 24 hours after death To the Funeral Director: completely filled in by the	ledical Co			hysician: To the miner: On the b and man	asis of	examina	tion and/or i	nvestigation	i, in my o	pinion, dea	ath occurr	ed at the time,	date a	and place,	and due to	the cause(s)
		within 2 To the comple	Me	29b. Signature and title of	certifier					29	c. Licens	e number			29d.	Date signe	ed (Month, D	Day, Year)
		- > - 0)		-			D	142	21		/	. 2	9.05	
		3+1		30. Name and address of	reson who	completed cau	se of d	eath (Iten	23a) (Type	Print)	SLL	10	B	2LT.	K1	0 2	122	,
		Sta Registr		31. Date filed (Month, Day		32	Registra	ar's Signa	ture	roste								
				. —			-		-									

1s	Campbel	T	1 - For Unpend Item 2	State of Maryland / Depa 23a&27 per me G840 2	artment of Health and I	Mental Hygie	ene	
			Decedent's Name (First, Middle, Last,			2. Date of Death	2005	3. Time Death
	Physici /Medi		Trevis	E.	Campbell	January	$2\overset{\text{Day}}{7}$, $20\overset{\text{Oar}}{5}$	0132A. M
	Examir		4a. Facility Name (If not institution, give St. Agnes Hospita		4b. City, Town, or Location of Death Baltimore	1	4c. County of Dear	h
20	Funeral Director		220-92-7190	XM 2□F 7. Age (In yrs. last birthday) XM 2□F 31 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign untry) MD
1	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary -f sho	tor	MD NA	Baltimo	re			1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 17 Brubar Ct Ap	+ C	10f. Zip Code 21207	10g	. Citizen of What Co	
	eath is 23	erai	11. Marital Status			pooity Vos or No	14. Race - Ame	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If them 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Madical Exametating institute anoilliest alonge.	ρ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerton I Yes	o Rican, etc.)	Black, Whit	
9-0	72 hou	ted	15. Decedent's Edu (Specify only highest grad	cation 16a. Deced	lent's Usual Occupation	16	b. Kind of Business/	Industry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work		Countre	Erecah
2	iled w tygier ther ti	Col	12th grade 17. Father's Name (First, Middle, Last)	4yrs Mark	eting Sales Re		Country	rresn
Maryland 21215-0036	ould be f Mental H Mrked of	To Be	Charles Savage		Gloria	Campbel	.1	
	and 2 sh eith and 27 is m		19a. Informant's Name/Relationship (Ty Gloria Campbell		g Address (Street and Number or Ru Milford Ave,			(ip Code) 21207
3altimore,	ages 1 a nt of He :: If Item		20a. Method of Disposition 1 □ Buriał 2 ②Cremation 3 □ F		sition (Name of natory or other place)		c. Location - City or	
ij	artmel		 4 □ Donation 5 □ Other (Specify) 21. Signature of Føneral Service Licens 		rematory Inc.	2/3/05 E	salt1mor	e, Ma
Ba	permi Depa Impo any id		Jole W	Jarch M4	Name and Address of Facility arch F/H West 300 Wabash Ave			21215
	Physician		Immediate Cause (Final	cations that caused the death. Do not enter the death on each line. Anomalous Left Mai:			•	Approximate Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	n coronary Artery			
п	Examiner		Sequentially list conditions.).				
1	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dualto (or as a consequence of).				
^_`	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed obysicien and the burial-transit	dical		l				
9		Medi	IE EEMALE:					
. Box	death certifice e attending ph id for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	at the de I by the a stached	Phys	9 🗆 Unknown	9□ Unknown				
ords,	w requires tha been signed should be del	by	Part II. Other significant conditions cor	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to	
Vital Records,	has has	Completed				24a. Was an autopsy performed	i? death?	topsy findings available ompletion of cause of
ital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical		26. Place of Deal	1 X Yes 2 ☐ th (Check only one)	No I LN es	2 No
) \(Physic this ce al direc	To	examiner?	ospital: 1 Inpatient 2 ER/Outpatient		ome 5 Residence	e 6 NOther (Spec	ify) (scene)
Division of		Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c, Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Divis	al or Atters after de I Directo	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	ician: To the best of my knowledge, death her: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	^D 2005
	, ser	'	30 Name and address of parson who are	mpleted cause of death (Item 23a) (Type, F	Print) 111 Popp St			1 01
	DOLT		ANA RUG	310 , MD	Print) III Penn St.,	Baltimore	e, Marylar	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3	32. Registrar's Signature	Joseph			

			for State Registrar	State o		nd / Depa		t of H	lealth a	and M	lental Hy		0.00	n c	020	05
			Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		JJ	3. Time of	Death
	Physic /Medi			John	David C	offe1t					Month Februa:	ry 1	, 20)05	5:52	АМ
	Examir		4a. Facility Name (If not institution	-	mber)		4b. City,	Town, or	Location	ol Death				of Death		
			26004K Brigadi					amas					Mor	ntgom	ery	
	Funeral Director		5. Social Security Number 218-80-2702	6. Sex 1⊠M 2□F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March 5	v. Year)	59	9. Birthp Cour Mary	lace (State o etry) Land	r Foreign
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. C	ty, Town or Lo	cation							1	0d. Inside Cit	tv Limite
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OT.	0 0		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Mo	cemetery, crei	natory or of	ther place	e) L	ebru 2005	ary 3				arylan	a
Baltimore,	그 된 본 등		21. Signature of Funeral Service		CI	ematori 22	Namean	d Addres	s of Facilit	h/			_			
ä	Depa Impo any ii		Kuthe	me -	M001	98 Rc	bert West	A. F Mon	Pumph: tgome	rey rv A	Funeral ve., Roc	Hom kvil	e/Ro	ockvi MD 20	11e, I 0850-280	nc.
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):			of admile by	(1)						
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Ö	death certificate e attending phys d for use as the	Med	IF FEMALE:									- 1				
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1□ Certifyin	g Physician: To the	best of my kno	wledge, death	occurred a	it the time	e, date and	d place, a	and due to the d	ause(s)	and mar	nner as sta	sted.	V
	he Ho in 24 he Fu	edical	(Check only 2 Medical I	Examiner: On the band man	asis of examina ner stated.	tion and/or inv	estigation,	in my op	inion, deat	h occurre	ed at the time, o	date and	place, a	ind due to	the cause(s)	
	With To 1	2	29b. Signature and title of certifier	T. 1	in	1 - Mr	29c.	License		10	- 2	29d. Date	signed	(Month, E	Day, Year)	
	5	116	patricia	10mste		y, M		V	519	16		rek	0. /	1 26	115	
	13		30 Name and address of person	at Mai	e of death (Item	23a) (Type.	Print) //	p:	Lo	01	10 0	L	1.5	16 1	MD AM	ocn
	Sta	te	31. Date filed (Month, Day, Year)	15/CO /VUL)	egistrar's Signa	/\UU/	V11/E	F11	15	0-/0	KE	CK	VI	re, 11	14 200	22
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					15.6 V		PAGE SHOPE									

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) BERNARD CHARLES DILLIAN JANUARY 31, 2005 **Physician** 1:55P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE IVY HALL NURSING HOME MIDDLE RIVER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 12XM 2□ F 85 213-09-2039 Yrs 9-9-1919 MARYLAND Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo MD BALTIMORE ROSEDALE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2340 HAMILTOWNE CIRCLE 21237 U.S.A. Funeral deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FIELD ENGINEER BENDIX CORPORATION 9 other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic syst Pages 1 and 2 should be nent of Health and Mental JOSEPH DILLIAN CARRIE (MORRISON) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itsm 27 is
sny injury or other trau ELEANOR DILLIAN/WIFE 2340 HAMILTOWNE CIRCLE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS CEM. 2-6-2005 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ardiae Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 Yes 2 2 No 1 🔲 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel [completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number D-38-7-54 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN BWD. WASERM histrar's Signature 31. Date filed (Morth, Day Your) State Registrar

			1 – For State Registrar	State of Maryla		artment of I		Mental Hy	rgiene Reg. N2 0 0 5	03007
			Decedent's Name (First, Middle, Last	it)				2. Date of De	aath	3. Time of Death
	Physic		James Grego	Dougherty,	Ir.			Januar	y 30, 2005	6:00P M
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deal		4c. County of De	
	Exami	lei	7016 Beechwood D	rive		Chevy	Chago		Montgom	0211
	Funeral				rs. last birthday,	If Under 1 Year	If Under 24 Hrs		rth 9. E	Sirthplace (State or Foreign
	Director		571-32-7125	7. Age (In)	79 Yrs.	Months Days	Hours Min.	Jan. 1	3, 1926 N	Country) lew York
			Usual Residence of Decedent					, , , , , , , , , , , , , , , , , , , ,		
	ylan		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Mar.	ior	Maryland Montgom	erv	Chevy Ch	ase				ty⊒Yes 2□No
	r 28	Director	10e. Street and Number		-	10f. Zip Code			10g. Citizen of What	Country?
	h wit		7016 Beechwood Dr	ive		20815	5		United Si	tates
	deat	by Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No	14. Race - Ar Black, W	merican Indian,
9	after or ite	E	1 Never Married 2K Married	1 X Yes 2 □ No W	orld	1 ☐ Yes 2 ☑ No		10 7 110411, 010.7	Specify:	inte, etc.
93	ral;		3 □Widowed 4 □ Divorced		ar II		opouny.		Specify.	White
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<u>ya</u>	Men	P.	Gregg Dougherty					ly Basse		
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Baltimore,	permit. Pages 'Department of H importent: If ite any injury or of		21. Signature of Funeral Service Licen	S00	Be	2. Name and Addr ethesda-(ess of Facility RO Chevy Cha	bert A. se. Inc.	Pumphrey L 7557 Wise	Funeral Home/ consin Avenue
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	/Medical		resulting in death)	Due to (or as a con-	sequence of):					
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0,	e exe		resulting in death) cast	Due to (or as a con:	sequence of):					
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9	artific ing p	Mec	IF FEMALE:							
Вох	eath certifi attending I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3[∃Ectopic pregnand	5 y		23d. Date of d Month	delivery Day Year
	ne des the al	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5[Other (specify)			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 4,
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ord	w require been si should b	ted						10	Yes 21∏ No 3□	Probably 4 ∐Unknown
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H		Con						perfo	ormed? death' 2X No 1 ☐ Ye	? es 2□No
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of V	nysicie	10	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2	≥ ☐ ER/Outpatie	nt 3 DOA	her: 4 🗆 Nursing I	lome 5 X Resi	dence 6 □Other (Sp	pecify)
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<u>ö</u>	Attending ir death. ector: After by the fune	atlo	2 Accident investigation				Yes 2 □ No			
Division	i or Attend efter death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spi	t home, farm, st	reet, factory, office		28f. Location (Street and Number or a wn, State)	Rural Route Number,
	To the Hospital or At within 24 hours efter d To the Funerel Direct completely filled in by	Certification:		3,						
	lospi hou uner uner	cal	29a. Certifier (Check only 2 ☐ Medical Exem	ysician: To the best of my liner: On the basis of exam	knowledge, deat	h occurred at the to	me, date and place	e, and due to the	cause(s) and manner	as stated.
	the H in 24 the F iplete	Medical	one)	and manner stated.						
	To 1 To 1	Σ	29b. Signature and title of certifier	Y1-M-		29c. Licen.	se number		29d. Date signed (Mo	nth, Day, Year)
			/	1		D003	3293		January 31	, 2005
	15+1		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)				
_	17		Frederick P. Smi	th, M.D. 54.	54 Wisco	nsin Ave	nue, Che	vy Chase	, Maryland	20815-6908
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si		1 .				-
	Regist	rar	FEB 03 2	005 Malue	11- 1	parti.				

	State of Maryland / Department of Health and Months and	, ,	ne 2005 (3008
Physician		2. Date of Death	Pay 2005	3. Time of Death 2:16 PvM
/Medical Examiner	Eleanor Roxanna Ellis 4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER 4b. City, Town, or Location of Death LA PLATA, MD	1	4c. County of Death	2.10 1.01
Funeral Director	5. Social Security Number 6. Sex 1 1 M 2 AF 86 Yrs. 1 Months Days Hours Min. 104-12-6498 Usual Residence of Decedent	8. Date of Birth (Month, Day, Yea April 13	9. Birthplac Country 1918 Warr	ce (State or Foreign en Cty, NC
aryland	10a. State 10b. County 10c. City, Town or Location		10d	I. Inside City Limits
death with the Maryland ons 23a or 28e-1 show in must be notified at meral Director	Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country	1 X Yes 2 No
23a or	3296 Captain Dement Drive 20603	τ	J.S.A.	
Ifeanore, Maryland 21215-0036 Iltimore, Maryland 21215-0036 Init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar saffment of Health and Mental Hygiene. Ordent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show injury or other treumetic event, the Madical Examination must be multiled at a finite or other treumetic event, the Madical Examination must be multiled at a finite or other treumetic event.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto F 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: 1 Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	o
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aryland 212' 2 should be filed within and Mental Hygiene. Is marked other then aumetic event, the Mental the M	Saint Paul Green Roxanna		en Sumame)	
Maryla Maryla d 2 should th and Men 7 1s marke treumetic	19a. Informant's Name/Relationship (Type, Print) Opal Jones (Daughter) 19b. Mailing Address (Street and Number or Rural 3296 Captain Dement Dr.			ode)
altimore, M mil. Pages 1 and 5 partment of Health y portent: If item 27 1 1 y injury or other tre	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c.	Location - City or Town	n, State
Baltimo permit. Page Department of importent: if any injury or ance.	21. Signature of Funeral Service Lie nsee 22. Name and Address of Facility R. H. Greene Funeral 109 S. Front St., W	Home		
Physician	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or head failure. List only one cause on such line. Immediate Cause (Final	r respiratory arrest,	- A	pproximate nterval Between Inset and Death
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rds, P, quires that the nation is signed by all the detaction of the property	Part II. Strict Significant Sentences Continuously to death out not resulting in the directlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
Division of Vital Records, I or Attending Physicien: The law requires talter death. Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed by		24a. Was an autopsy performed?	? death?	y findings available letion of cause of
Vital Ficien: The certificate sector, page	25. Was case referred to medical 26. Place of Death	(Check only one)		
on of Vital Ruding Physicien: The h. After this certificate h. funeral director, page	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Other: 4 ☐ Nursing Hom	ne 5 Residence		
ision (ittending F death. ctor: After / the funer	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at 28c. Injury 28c		,-,	
Division c	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street City or Town, Sta	and Number or Rural F ate)	Route Number,
he Hospi n 24 hou he Funer bietely fill	29a. Certifier (Check only one) 29a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, at 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause od at the time, date a	(s) and manner as state and place, and due to th	ed. e cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License number D-22574	29d. [Date signed (Month, Da	y, Year)
П	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PACE, ROBERT T., MD 12070 OLD LINE CENTER WAL	DORF. MI	D 20602	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	· - y 111		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. UU5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Mariano Giusseppe Ferraro January 27, 2005 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harborside Health Care Baltimore N/A 5. Social Security Number 219–28–7761 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Italy **Funeral** 8. Date of Birth (Month, Day, **1**X□M 2□F Months Days Year) 91 Hours Director January 23, 1914 Usual Residence of Decedent 10a. State 10b. County ?7 is marked other than "natural", or itams 23a or 28a-f show troumatic event, its Madical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director **Maryland** N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3126 Woodring Avenue 21234 USA death 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mentat Hygiene. Int: If item 27 is marked other then "natural", or ite Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5th College (1-4or 5+) Cabinet Maker Wood Work 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Unknown Ferraro Carmela Fondanazza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: if item 27 is
any injury or other treu Anna Ferraro-Wife 3126 Woodring Avenue Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 1/31/05 Timonium Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland Hilton suna 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arade I O Panietul **Physician** STROUTO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien for use as the buria by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I 23e. Did tobacco use contribute to the cause of death? page 2 should be inome Be Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) Manner of Death

1 Satural
2 Accident after death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei C The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my option death occurred at the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) To the 29b. Signature and till of certifier 29c. License number D 253 91 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, 21235 31. Date filed (Month, Day, Year) Fegistrar's Signature State FEB 03 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1509 Carol Glenn 29 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hosp. Harford Bel Air If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Yrs. 218-44-3073 11-10-48 Md. 56 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Md. Harford Bel Air Y☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1509 Redfield Rd. 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schools Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore City Public 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Sparks Alma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 1709 St. Paul Street Son Apt. 202, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State King Mem. Park 2-4-05 Randallstown, Md. 22. Name and Address of Facility Baltimore, Md. 1101 E. North Ave. 21202 March F.H. East Approximate Interval Between Onset and Death INFARCTION ACUTE MYOCARDIAL Due to (or as a consequence of): MILLURE RESPIRATORY Due to (or as a consequence of): PLEULAL Due to (or as a consequence of): BREAST YEARS METASTATIC CANCER 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA

Baltimore, Maryland 21215-0036 Vital Records, P.O. Box 68760, o Division Hospital the

Physician

/Medical

Examiner

Directo

Funeral

2

Be

Funeral

Director

marked other then "natural", or items 23a or 28a-f show matic event, the Mccleal Examinar must be notified at Pages 1 and 2 should be fill ment of Health and Mental Hy ant. If item 27 is marked oth ပ 19a. Informant's Name/Relationship (Type, Print) Leonard Sparks 20a. Method of Disposition Important; If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licent ee once. 23a/ Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ng physician as the burial Completed by Physician/Medical attending IF FEMALE: use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown ached for the deta signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMOTHERAX page 2 certificate director. Be 25. Was case referred to medical examiner? Hospital: 1 Department 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Oate of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide filled in within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HS5922 FEBRUARY 1, 2005 DO 500 UPPER CHES APEAKE DRIVE

State Registrar

DHMH 17 Rev 1/2001

BELAIL, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUDITINT 31. Date filed (Month, Day, Year) SAMPHILIPO

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 11, 2005 Elisebeth T. B. Grenata 1:50 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Buckinghams Cheice Adamstown Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 1907 5. Social Security Number 9. Birthplace (State or Foreign Country)
IIIIn●is 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖾 F Yrs. 97 Director 188-36-8588 Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mentei Hyglene. Important: if item 27 ie marked other than "natural", or items 23a or 28a-f ehow way lijury or other treumatic event, the Madical Examinat must be notified at Page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Adamstown MD Frederick 10e. Street end Number 10g. Citizen of Whet Country? United States 10f. Zio Code 3200 Baker Circle 21710 America Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. Specify: \$ 3K Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Tayler Ella Louise Palmer 9 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Taylor/ Nephew 2025 Mummasburg Read Gettysburg, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Darial 2 Cremation 3 Removal from State 1/13/05 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery Leesburg, Virginia 22. Name and Address of Facility Colonial Funeral Home 201 Edwards Ferry Road NE Leesburg, Virginia 20176 21. Signature of Funeral Service Licenses muce 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner anding physicien end use es the bunal-trensit or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) eath but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? astroesophagean 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificata 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of within 24 hours after deeth.
To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2☐ Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 House 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar 2005

			1 - For State Registrar	State of Maryland			Ith and M		_	5 03012
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)	Gough		*		2. Date of Death Month	Day 30	
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	Physic	ian	Decedent's Name (First, Middle, La	•			mouto or	Douth	2. Date of Dea Month	Day	05 Year	Time Death O 13.5 AM
	/Medi Examii		Richard E. Gre 4a. Facility Name (If not institution, give \$\frac{1}{2} \tag{6} \tag{8} \tag{5}\$				4b. City, Town, o	or Location of Dea		4c. Cou	2005 nty of Death	0123 //
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	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimo	re	10c. City, To	own or Loca					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
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21215-0036	within 72 ho nne. .han "natur na Medicul	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Give ki life. Di	O NOT use retired	during most of we	orking		Business/In	dustry
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	nd 2 salth ar 27 is	1		Son-in-Law					Woodlawn			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or othar trai		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Specif		1		tion (Name of tory or other place Mem . G		Date 7/2005 1	20c. Locatio		
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			1 - For State Registrar			ertificate of			200	5 03014
	Physici	an.	1. Decedent's Name (First, Middle, Last)			-		2. Date of Death Month		3. Time of Death
П	/Medic	al	Claire Louise Seal		ne Gisine			February		
	Examin	ier	4a. Facility Name (If not institution, give s Keswick Home	itreet and number)		Balti	or Location of Death	1	4c. County of De	am
	Funeral		Social Security Number 6. Sex		e (In yrs. last birtho			8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		217-20-9074	M 2 X F	92 Yrs	. Wortus Days	Tiodis Will.	October 1	3,1912	Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e-f sh	tor	Maryland N/A		Baltin	nore				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (
	eath v	erai	700 W. 40th St.	12. Was Decedent I	Everinits	2121		posify Vos er No	United 1	States
മ	after d	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N		3. Was Decedent of I		o Rican, etc.)	Black, Wh	
5-0036	should be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other then "naturet", or trems 23e or 28e-f show marked other then "naturet", or trems are mast be natilised at metic event, it a Marical Examiner must be natilised at	d by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
7	n 72 h	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. De	ecedent's Usual Occup ive kind of work done e. DO NOT use retire	oation during most of won	king 16	6b. Kind of Busines	s/Industry
212	d withi	mo	Elementary/Se <i>co</i> ndary (0-12)	College (1-4or 5	+)	ephone ope			telepho	one company
힏	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)				7	ne (First, Middle, Ma		one company
yla	should band Ment marked meric o	2	Frederick Charles				Emma Me			
Maryland 2121	2 6 8 6		19a. Informant's Name/Relationship (Ty) Edward Clautice/cou			ailing Address (Street Carol Rd				
	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	20111		sposition (Name of crematory or other pla			C. Location - City of	
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 XCremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	i	unt cremat	I	7 2005 B	altimoro	Maryland
Baltimore,	permit. Pages Dep. rtment of Importent: If it any injury or o		21. Signature of Funeral Service License	10 11 TV	Total Cest Ellio	22. Name and Addre	ess of Facility nell-Wied	efeld Fun	eral Home	P. Inc.
_	205 29		John O. Thut	rell		22. Name and Addre MI CC 6500	York Rd.	Baltim	ore, MD	21212
			23a. Bar1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final	e cause on each lin	the death. Do not			or respiratory arres	t,	Approximate Interval Between Onset and Death
ı	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	e str	ICE			Hours
	Examiner		Sequentially list conditions	(typer	tensi	M			Jeans
	sit ad	iner	Sequentially list conditions, in my law ingressions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a con equance of):					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	. Due to (or as	a consequence of);					
/60	0 0	caiE								
9	eath certificat attending phy I for use as th		IF FEMALE:							
Rox	death certifica e attending ph ed for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 Fetal death	3 Ectopic pregnanc	y		23d. Date of de Month	elivery Day Year
	0 0 0	Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)				,
ت. ح.	The law requires that the te has been signed by thoage 2 should be detache	by Ph	Part II. Other significant conditions con	tributing to death bu	at not resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Zg	w require been sig should b	ted b	Renentia		1+			1 ☐ Yes	2 00 3 □ F	Probably 4 Unknown
Vital Hecords,	lawr nasbe e 2 sh	Completed	obstruction	e Lun	g disen	ce		24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u>e</u>				_				performe 1 □ Yes 2 €		s 2□ No
	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	nt 2□ER/Outpa	tient 3 DOA Oth	200	th <i>(Check only one)</i> ome 5 🗆 Resident	C [70*b/0-	
0	g Phys ter this neral di	-	27. Manner of Death	28a. Date of Injury (Month, Day)	v 28b. Time	of 28c. Injur	y at	28d. Describe how		вспу)
<u> </u>	Attending ir death. ector: Afte by the fune	catic	1 Natural 5 Pending 2 Accident investigation	(INGILIT, DA)	rour, injur		Yes 2 □No		_	
DIVISION	of or Attending Patter death. I Director: After the in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Stree City or Town,		Bural Route Number,
	To the Hospitef or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier 12 Certifying Phys	ician: To the best o	of my knowledge, de	eath occurred at the tir	me, date and place,	and due to the caus	se(s) and manner a	s stated.
	he Ho in 24 ł he Fu pletely	edicai	(Check only 2 Medical Examir one)	ner: On the basis of and manner sta	examination and/or	r investigation, in my o	pinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	Tot For	Σ	29b. Signature and title of certifier	D. 0	9	29c. Licens	e number		Date signed (Mon	
	0.		My Hothen	yiu	ey, un	W Vid.	2 407	1-	eprom	,2,2005
	1,		30. Name and address of person who co	6 Aug 1	570 (N-	Charles St	· balto.	ond 21	204	
	Sta		31. Date filed (Month, Day, Year) FFR 0 3 2	32. Registra	r's Signature	Coarle				
	Registr	217	A R R R R R R	JUJ 3 57 66	CANADA AND					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem 21 per fh 8840 2-3-05 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Ronald L. Grav 22:45 PM 35 2005 aculary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Ballirrore (IT Under 1 Year If Under 24 Hrs.) Baltimore Hospital 8. Date of Birth (Month, Day, Year) 01-07-1960 6. Sex 12 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months Hours 218-84-6637 45 Maryland Director atient Known as Konald Gray Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1X Yes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 21215 USA 4413 Elderon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: <u>م</u> If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other then any injury or other trainmain. Elementary/Secondary (0-12) 12. College (1-4or 5+) Roofer Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucious Gray Elouise Beatty ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Boone/ Sister 4413 Elderon Avenue Balto, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cemetery 02-05-05 Lansdowne, MD ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Albert Wylie per dyr Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endora 5 days Infective /Medical Due to (or as a consequence of) Examiner ocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit 0 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown à been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 No 1 Yes the Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this e 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year) Tatlor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Juzan ratton Hospital

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 03

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment rtificate			ınd M	_	giene (005	03016
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ith		3. Time of Death
1	Physic /Medi		MILORED H GU	ILFOY						FEB	Day	12000	1442 M
	Exami		4a. Facility Name (If not institution, give			4b. City, T	own, or l	Location of	f Death	1 - 1		nty of Death	
			UNIVERSITY OF MAKYLAN	ID MEDICAL C	ENTETL		MAR				N	/A	
	Funeral		5. Social Security Number 6. Sec. 10 10 0439	JM SISTE	(In yrs. last birthday) 70 Yrs.	If Under 1 Months	Year Days	ff Under 2 Hours	Min.	8. Date of Birt (Month, Day	r, Year)	9. Birth Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		78 Yrs.					Aug. 5,	1926	Ma	ryland
	yland		10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
	e Ma	ctor	Maryland Anne Ar	undel	Pasaden	a							1 ☐ Yes 2X No
	h with th	al Director	10e. Street and Number 1527 Long Point	Road		10f. Zip (Code 21122	2			10g. Citizen		intry?
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23e or 28e-f show other treumatic event, Ite Medical Examinat must be modified at	d by Funeral	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Deceder f Yes, specif	y Cuban,	panic Orig , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)	E	tace - Ameri Black, White, cify: Whi	etc.
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)									Business/In	,			
121	within lene. than	Completed	Efementary/Secondary (0-12)	College (1-4or 5	+}	oo NOT use chers	,				CT	T F	School
	filed Hygie ther		17. Father's Name (First, Middle, Last)	2 years	Tea	CHELS		IS Mother	'e Name	(First, Middle,			Frances
Maryland	2 should be and Mental Is marked o	To Be	Frank Ha						Cece	lia Pur	cocha:	r	
	1 and 2 sh Health and Iem 27 Is rr		19a. Informant's Name/Relationship (Ty Irving J. Guilfo			g Address (Route Number Pasade			o <i>Code)</i> nd 21122
Baltimore,	eg = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dispo- cemetery, cren Cedar Hil	natory or oth	er place)		_{Da} /5/2		20c. Location		own, State Maryland
Baltin	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service License	90	22	. Name and	Address	of Facility	Gor	ce Fune	eral S	ervice	e, P.A.
	40244		23a. Patri. Enter the disease, or compli	ropulle	- 6	001 Ri		_	-			, Mar	yland 21225
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	CEREBR	O VASCULAR consequence of):			Such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death DAY S
	Examiner		Sequentially list conditions	1		PARCT	ON						·
	p ti	Examiner	Sequentially list conditions, if any, is a fine to immediate cause. Enter Underlying Cause (Disease or injury		donaciones cit:								
	cate be executed physicien and the burial-transit	Kam	that initiated events resulting in death) Last	Due to (or on								11/1	
8760,	be ey icien buria	aiE		DOB (0 (0) 45 a	consequence of);								
387	phy:	edicai											
.O. Box (that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pred Other (spec						Pate of delive	ery Day Year
۵.	that the by detact		Part II. Other significant conditions con	tributing to death bu	t not resulting in the un	derlying cau	se given	in Part I.		23e. Did tot	acco use co	ntribute to th	ne cause of death?
ords	w requires been sign should be	ted by	HYPERTENSION DIABET	IES MELLIT		DESTE	role	MIA	_		s 2 No		ably 4 Unknown
Vital Records,	The lar te has age 2	Completed							_	24a. Was a autops perform	V	prior to cor death?	psy findings available mpletion of cause of
/ita	certifical	Bec	25. Was case referred to medical examiner?				2	6. Place o	of Death	Check only on		1 1 1 1 6 5	26 140
of \	S S S	P	1 ☐ Yes 2 No	ospital: 1 Inpatien	t 2 ER/Outpatient	3□ DOA	Other:	4 🗌 Nurs	ing Hom	e 5 🗆 Reside	nce 6 🗆 O	ther (Specify	()
n c		ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		. Injury at Work?			d. Describe ho	w infury occu	ırred	
isio	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	One Disease of Initial		М		s 2 No		W 1 41 (0)			
Division	after of Direct	ertification;	4 ☐ Homicide determined	building, etc.	y - At home, farm, stre (Specify)	el, factory, d	office		28	City or Town	eet and Num , State)	iber or Rura	l Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier Certifying Phys	ician: To the best of	my knowledge, death	occurred at	the time,	date and	place, an	id due to the ca	use(s) and n	nanner as st	ated.
	the H lin 24 the F	Medical	one)	and manner state	examination and/or invi	estigation, in	my opini	ion, death	occurred	d at the time, da	te and place	, and due to	the cause(s)
	ToT	2	29b. Signature and title of certifier			29c. L	icense n	umber	10	29	d. Date sign	ed (Month, L	Day, Year)
•	√.		1 Apm Misey	21	4D		P 1	777	y of		2/1/	05	
_	Λ		30. Name and address of person who con ALAN KUSAKABE 2	mpleted cause of dec	ath (Item 23a) (Type, F LANVALE 3		BA	IJIM.	DE.	MD 21	217		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar									
	Registra	ar	FEB 0 3 2005	Bern	A GOO	EL)							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 01,2005 **Physician** STANISLAW GEMBICKI 4:50 рм PAUL /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 766 G Street Pasadena
If Under 1 Year | If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) May 26, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 216-14-8933 80 May Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 INo Maryland Anne Arundel Pasadena Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Street 21122 U.S.A. death Funerai 766 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Defense Investigation Elementary/Secondary (0-12) College (1-4or 5+) Service 12 Computer Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked other no or other traumatic event Gardocka Gembicki Antonina Stanislaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 766 G Street, Pasadena, Maryland 21122 Edith M. Gembicki (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 02-02-05 Baltimore, Maryland Bayview Crematory 21. Signature of Fund Service Licenses McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 P. (1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician neumon resulting in death) /Medical Due to (or as a consequence of) Examiner MONTH 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-68760. Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Year 5 Other (specify) signed by the a Id be detached f ☐Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 4 Nonknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 Yes 2 2 No certificate 2 🖾 No 1 🗆 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Many of Death completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/2/05 Da2102 Nanbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFROZE MUNEER 90 E. Fort are tallinge MD 21230 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 3 2005

RJ			1 - For Unpend Item Registrar	23a,27,28	laryland/Depa Sa i per me Ce	artment <u>of</u> He rtificate of D	alth and l eath	Mental Hygi Re	ene g. N2 0 0 5	03018
	Physici	_	1. Decedent's Name (First, Middle, La Denise	st)	Harpe	er		2. Date of Death Month January	Day Year	3. Time of Death OO:28 A.M
	/Medio Examin		4a. Facility Name (If not institution, giv Johns Hopkins E)	4b. City, Town, or L			4c. County of Death	
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last birthday) 43 Yrs.	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8–22	Year) 9. Birth	place (State or Foreign intry)
7			Usual Residence of Decedent 10a. State 10b, County		10c. City, Town or Lo	ocation		0-22	-01 1	10d. Inside City Limits
	Maryland	tor	Md. NA		Baltin					Y☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show rmust be rollited at	Funeral Director	10e. Street and Number			10f. Zip Code	224	10	g. Citizen of What Cou	intry?
	eath w	eral	344 Joplin Str	12. Was Decedent	t Ever in U.S. 13.		224	pecify Yes or No-	USA 14. Race - Amer	ican Indian.
920	or Ita	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 Yes 2 If If Yes, Give A Year or Dates:	No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2🏋 No	Mexican, Puert Specify:	o Rican, etc.)	Black, White	, etc. Lack
21215-0036	c = 36	Completed	15. Decedent's E (Specify only highest gra	ade completed)	lite.	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of wor	king	6b. Kind of Business/li	ndustry
212	d within giene.	Somp	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	al Sterile	e Proces	sor	Bayview	
	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the M	Be	17. Father's Name (First, Middle, Last		arter Cr	1		ne (First, Middle, M		
Maryland	should nd Mer marke	၀	Randolph 19a. Informant's Name/Relationship (arter, Sr.	ng Address (Street and	Delor		Burrell City or Town, State, Zi	
Ĭ,	and 2 ealth a n 27 is		Allen Harper, Jr	. Husba		Joplin Str	ceet, Ba			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic e one.		20a. Method of Disposition 1 Burial 2 Cremation 3 Communication 3 Communicati		9 '	matory or other place)	1		20c. Location - City or T	
altin	permit. P. Departme Important any injury once.		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices			OF Faith Ce 2. Name and Address		Baltimon	Baltimore, re, Md. 21	.202
8	8 3 5 8		7	1-7-		March F.H.			North Ave.	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each I	c (methadone			or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a	s a consequence of):					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. The though the Cause (Disease or injury that initiated events	b. Due to (or as	s a consequence of):					
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
68760,	icate be execul physician and s the burial-trar	edical		_ d						
Box 6		//Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			70,000,000		23d. Date of deliv	rerv
o.	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown			Ectopic pregnancy Other (specify)			Month	Day Year
rds, P	luires that n signed b	by	Part II. Other significant conditions of	contributing to death I	but not resulting in the u	nderlying cause given	in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pro	11 666 1
Records,	law requasis been	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
alB	n: The lav ficate has or, page 2		GE Man ann referred to medical				00 Blood (B)	perform 1 X2 Yes 2	□ No 1 1 No Yes	2 No
of Vital	ysiclan: is certifica director, p	To Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpati	ient 2 X ER/Outpatie	Other		th (Check only one ome 5 - Resider	nce 6 Other (Speci	fy)
	Attending Physiclan: r death. sctor: After this certification the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Date of Injury) 1-29-05	ay Year) Injury	Work?	at es 2 X ∐No	28d. Describe how	w injury occurred u	nk
Division	in Jir	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace of III	njury - At home, farm, st etc. (Specify)	reet, factory, office		City or Town,	eet and Number or Rur State) 344 Jon Maryland	lin St.
	A Hospital	Medical (29a. Certifier 1 Certifying PI (Check only one) 2 X Medical Example 1	hysician: To the best miner: On the basis of and manner s	t of my knowledge, deat of examination and/or in stated.	h occurred at the time, vestigation, in my opin	, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Trithe 2 complete	Me	29b. Signature and tibe of certifier	11 11		29c. License r			d. Date signed (Month, January 30,	
	111		30. Name and address of person who	completed cause of	de th (lum 23a) (Type.					2007
\	4		30. Name and address of person who THE WINT Mille	inf		111 Penn S	treet,	Baltimore	, MD 21201	
	Sta Registr	-	31. Date filed (Month Day Year) 3	2005 32. ist	trar's Signature	Conti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year HARRIS

7. Age (In yrs. last birthday)

95

Yrs.

NATHANIEL

6. Sex

HOSPITAL

X☐M 2☐ F

4a. Facility Name (If not institution, give street and number)

AGNES

12:25 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

JANUARY BOTT, 2005

= 15 DAYS

Year

1 ☐ Yes 2 X No

JANUARY

8. Date of Birth (Month, Day, Year)

12/23/1909

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Days

Months

BALTIMORE

Hours

30

3002

Virginia

Black

4c. County of Death

Physician /Medical **Examiner**

Funeral

George

5. Social Security Number

227-07-3466

Usual Residence of Decedent

SHINT

Director the Maryland r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at WIT

Completed by Funeral Director

Be

ပ

Physiclan/Medical Examiner

þ

Completed

Be

To

Certification;

Medical

State

Registrar

(Check only one)

Anthony

31. Date filed (Menth, Day,

29b. Signature and title of certifier

Shme

03

NI 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonnie, MD

2005

filed within 72 hours after death and Mental Hygiene. es 1 and 2 should be filed of Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other or other traumatic event, it ₽ ± 5 permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

Priyaician /Medical Examiner

The law requires that the death certificate be executed burial-transit the ed by the a Records, P.O. Vital director. Hospital or Attending after death in by

10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 St. Agnes Lane Apt. 111 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 1943
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 8 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Harris Rebecca Robbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Barnock Court, Randallstown, Maryland 21133 Cynthia Jones / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Ceme.02/08/2005 Owings Mills, Maryland 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. ture of Funeral Secuce Licens 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PHEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERIPHERAL VASCYLAR DISEASE 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 2 **X**No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours a To the Funeral C filled i

To the

completely

ST. AGNES

MD

32. Resistar's Signature

29c. License number

116705

HEALIHCAKE, MARTLANN

			For			d / Depa	artmen	t of H	ealth a	and M	lental Hygi		gible.	
			1 - State Registrar			Cei	rtificate	e of L	Death			g. No.2	105	03020
Ph	ysici	an	1. Decedent's Name (First, Middle								2. Date of Death Month	Day	Year	3: Time of Death U
/1	Medic	al	Elizabeth Ha 4a. Fecility Name (If not institution		has		4h Cib.	Taum as	Location of	of Doorb	February		2005	10:00AM
Ex	camin	er	Charlestown Ca		U 0 1)								Ltimor	
Eur	ieral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under	1 Year	nsvi If Under	24 Hrs.	8. Date of Birth			olace (State or Foreign ntry)
Dire			214-40-5441	1 □ M 2X□ F	9	7 Yrs.	Months	Days	Hours	Min.	June 11,	1907	Mary	
pu »	122		Usual Residence of Decedent		100 Cib	y, Town or Lo								
aryla	in Di	7	10a. State 10b. County			•								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	offfic	Director	Maryland Balt 10e. Street and Number	imore	C	atonsv	ille 10f. Zip	Code		· · · ·	10	o Citizon	of What Cou	
with ga o	100	2	715 Maiden Cho	ice Lane				2122	0		10			nuy:
death	- mas	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.	.S. 13. \				gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	S.A. ace - Ameri	
6 after or tta	mine	Ē	1 X Never Married 2 ☐ Marri	ied 1 Yes 2	∑ [No		tYes, spec 1 ☐ Yes 2		n, Mexican Specify:		Rican, etc.)		lack, White,	etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. stherthan "naturel", or thams 23a or 28e-f show	Exa	d by	3 Widowed 4 Divorced	Year or Dat				ZEI NO	эреспу.			Spec	Wh	ite
Maryland 21215-0036 ad 2 should be filed within 72 hours aff th and Mental Hygiene. 77 is marked other than "natural", or	sdica	Completed	15. Decedent (Specify only highes			16a. Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>Juring m</i> osi	t of worki	ing 1	6b. Kind of	Business/In	dustry
withir than	Na Mi	dmc	Elementary/Secondary (0-12)	College (1-	4or 5+)		cipal	10 (10 (10 G)	,		1	T.J.,		
d 20 Hygir	ant, I	e C	17. Father's Name (First, Middle,			1 1 111	страт		18. Mothe	r's Name	(First, Middle, M	Educa aiden Sum		
ld be sental	ic ev	To Be	William F.C. I	Hartie					Ros	se Le	vhe			
ary shou	umat	_	19a. Informant's Name/Relationsh	5		19b. Mailir	ng Address	(Street a			il Route Number,	City or Tow	m, State, Zip	Code)
and 2	er tra		Joan Rasch (Cousin)		l Wile	1980 Oct 1980		ourt	Hi1	ton Head	, SC	29926	
Ore of He of He	or oth	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S		Place of Dispo emetery, cren	sition (Nam natory or of	ne of ther place	9)		Date 2	Oc. Location	n - City or To	own, State
timent tant:	jury	10000	`4 □Donation 5 □ Other (Sp	pecify)		klawn (-	į		·2005 Ba	1timc	re, M	aryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or thams 23a or 28e-1 show	any in		21. Signature of Funeral Service I	Licensee		- V:	. Name and	Fun	s of Facilit eral	y Home	of Cato ue Caton	nsvil	le. I	nc.
			23a Part 1 Enter the disease of	complications that cal	used the death								e, MD	21228 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final					o or oying	, 50011 05	0010100	, roopilatory arros	,,,		Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)		r as a consequ		Wel		_					nours
Exam	iner													
- B	. <u></u>	ner	Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Sue to (o	r de a euneuq	uente of):								
and and	-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (e										
1760,te be executed spician and	burial-transit	cal E		0) 01 600	r as a consequ	uence or).								
2 2 3	, <u>o</u>			d										
Box (Bath certif attending	use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. E	ate of delive	ery
. B death e atte	d for	Icla	in the past 12 months?	4□Pregna	th 2□Fetal nt at time of de		Ectopic pre Other (spe					4	Nonth	Day Year
P.O hat the	tache	hys	9 🗆 Unknown	9□ Unknov	vn									
VISION Of VITAL RECORDS, P.O. BOX 68 Attending Physicien: The law requires that the death certifica reach: Sector: After this certificate has been signed by the attending ph	d be detached for use as th	by F	Part II. Other significant condition	ns contributing to dea	th but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.					ne cause of death?
cord v requir been s	should	ted									1 ☐ Yes	2 No	3 [Prob	ably 4 Unknown
Records, The law requires te has been signe	2	Completed									24a. Was an autopsy performe			psy findings available mpletion of cause of
Vital Ficien: The certificate	r, pag										1□ Yes 2	No	1 Yes	2[2No
VIÇ sicier certil		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatien	t 3 DO	Othe			(Check only one)		/2	un me.
Division of Vital to Attending Physicien: 1 after death. Diractor: After this certificat	ras l	\vdash	27. Manner of Death	28a. Date of	Injury	28b. Time of		Bc. Injury	at	-	me 5 Residen 28d. Describe how			0
ION Path. P.: Afte	Ĕ	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year)	Injury	М	Work¹ 1 □ Y	? ′es 2 🗆 i	No				
	by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 200. Place o	f Injury - At ho	ome, farm, stre	eet, factory,	, office		1	28f. Location (Stre City or Town,	et and Nur State)	nber or Rura	l Route Number,
Dital o	led in		N	i .										0
DIVISION Hospital or Attended to the hours after death Funeral Diractor:	tely fii	edical	(Check only 2 Medical I	g Physicien: To the be exeminer: On the bas	is of examinat	wiedge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	and due to the cau ed at the time, dat	se(s) and r e and place	nanner as st e, and due to	ated. the cause(s)
Di To the Hospital or within 24 hours afte To the Funeral Dir	completely filled in by	Med	one) 29b. Signature and title of certifier	and manne	n Stated.		29c.	License	number		290	. Date sign	ed (Month,	Day, Year)
⊢ ≯ ⊢	Ö		me not		S	_	7	70	000					
-	n		30. Name and address of person	who completed cause	of death (Item	23a) (Type, I	Print)	50	989		10	DIO.	nA.	טו בסט
^	V		NI L NA G	enter M	IIT C	Mai	don	C	noic	e L	n Codo	ivea	1/e 3	2528
	Sta		31. Rate filed (Month, Day, Year)	32 Re	gistrar's Signa	ture	roll I							
Re	gistr	ar	FEB 03	2005	eras s	ASTA								

State of Maryland / Department of Health and Mental Hygiene 03021 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gregory Charles Hartley 1:00 AM January <u> 26</u> 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4603 Millbrook Rd. Baltimore N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 217-52-5597 56 Director Maryland October 12,1948 Usual Residence of Decedent the Maryland show 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1XXYes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 Millbrook Rd. 21212 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. □Yes 2XNo 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygiens important: If item 27 is marked other the any injury or other traumatic August. Jesuit Priest Religious/Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vincent Aloysius Hartley Catherine Rita Farrell 19a. Informant's Name/Relationship (Type, Print)
Eugene Geinzer/ Rector of S.J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 N. Charles St. Baltimore, MD Community 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Jan. 29,2005 Woodstock, Maryland * 4 □ Donation 5 □ Other (Specify) Woodstock Cemetery Mitchell-Wiedefeld Funeral Home, Inc. Society Pd. Baltimore, MD 21212 21. Signature of Funeral Service Licenses Baltimore, MD 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final orgentive Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ava The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 lan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? Month Dav Year Physica 4 Pregnant at time of death 5 Other (specify) P.0. detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown þ signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: Other: 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 WNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by determined 4 Homicide within 24 hours a To the Funeral D A Copyring Physicien To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical 9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 ed cause of death (Item 23a) (Type, Print) 30. Na necano 126 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 03 Registrar 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ALICE PATTERSON HARRIS January 10:00 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Presbyterian Home Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct. 13,1909 5. Social Security Number 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 95 212-40-5518 Yrs. Director Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ō or Items 23a 400 Georgia Court 21204 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene.
Ither than "natural, or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, Us. 1 and 2008. 12 yrs. Secretary Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hall Harris Jr. Lavinia Hawley Brush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Shea (Presby. Home Administrator) 400 Georgia Court Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 2/3/05 Greenmount Cemetery Baltimore, Maryland 21. Signat of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that daused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician M-0(4,00) Honte disease or condition resulting in death) 404,-1 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (of as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed 2. No 2 No 1 Yes 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1/2 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Attendon 1737016 31, 2005 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) By Himme. 6701 N. Charles St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2005 FEB Consider. Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

XXM 2□F

SINAI HOSPITAL OF

10b. Count

NA

William

10a State

5. Social Security Number

216-28-3392

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Thomas

71

BAUTIMORE

10c. City, Town or Location

Baltimore

7. Age (In yrs. last birthday)

Henry Jr.

4b. City, Town, or Location of Death

BAUTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

Days

2. Date of Death

JANUACY

8. Date of Birth (Month, Day, 06 04

28

Year) 33

2005

4c. County of Death

Month

3. Time of Death

8:15 P

10d. Inside City Limits

1 Yes 2 □ No

9. Birthplace (State or Foreign

ЙC

st)				2. Date of I	Death		3. Time of Death
				Janua:		2005°	2:05 a M
L		4b. City, Town, or	. I continue of			unty of Death	2.05 a
street and number)		Pikesvil		Death	1	timore	
	(In yrs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of 8			lece (State or Foreigi
□M 215 86		Months Days	Hours	May 2	Birth (Day, Yeer) 1918	Mar	lece (State or Foreign stry) y Land
••	10c. City, Town or Lo Baltimore	cation				1	0d. Inside City Limits 1 ☐ Yes 2 No
ce	baltimore						1 L Yes 24 No
		10f. Zip Code				of What Cour	-
L Road		21207				State	
12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No- 14.	Race - Americ Black, White,	etc.
1 ☐ Yes 2√ N If Yes, Give	0	1 ☐ Yes 2 ☐ No	Specify:		Sp	_{lecify:} Whi	te
Year or Dates:	160 Door	dent's Usual Occup	ation			of Business/Inc	
ducation ade completed)	(Give	kind of work done of DO NOT use retired	during most	of working	100, Killa	OI DUSINGSS/III	dustry
College (1-4or 5-	Payro		,		City	of Bal	timore
			18. Mother	's Name (First, Midd	ile, Maiden Su	mame)	
			Carri	e Horney			
Type, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Nun	nber, City or To	own, State, Zip	Code)
ealdhall	1			altimore,	•		
	20b. Place of Dispo	sition (Name of	1	Date	20c. Locat	ion - City or To	
Removal from State y)	ew Cathedr	natory or other place al Cemete	erv F	ebruarv 1	2005	Baltime	ore, Mary
b. Due to (or as a	a consequence of): a consequence of): a consequence of):	2 Yurlu	w 20 v	,	230	. Date of delive	
1 ☐ Live birth : 4 ☐ Pregnant at : 9 ☐ Unknown	2 ☐ Fetal death 3	Ectopic pregnancy Other (specify)	' <u></u>			Month	Day Year
confidential to death but	1.	nderlying cause giv	en in Part I.		d tobacco use ☐ Yes 2 ☐ N		ably 4 Denknow
					topsy rformed2	th. Were auto prior to cordeath?	psy findings availabl npletion of cause of 2□ No
				of Death (Check onl	y one)		
Hospital: 1 ☐ Inpaties 28a. Date of Injur (Month, Day	v 28b. Time o	f 28c. Injur Wor	y at k?		esidence 6 [e how injury o		y)
e 28e. Place of Injubuilding, etc	ıry - At home, farm, str (Specify)		Yes 2□N	28f. Location	n (Street and N Town, State)	lumber or Rura	il Route Number,
nysician: To the best on niner: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, deat	place, and due to the control occurred at the time	ne cause(s) an e, date and pla	d manner as stace, and due to	ated. the cause(s)
		29c. Licens	e number		29d. Date s	igned (Month,	Dey, Year)
	40		7.7	The	11	3110	5
1	·/	1)	01.	3 0 -7	()	711	
dompleted cause of de	eath (Item 23a) (Type,	Print)	600	·T	00 R	0	21208
	completed cause of de	completed cause of death (Item 23a) (Type	dompleted cause of death (Item 23a) (Type, Print)	completed cause of death (Item 23a) (Type, Print)	completed cause of death (Item 23a) (Type, Print)	completed cause of death (Item 23a) (Type, Print)	completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department of Health and M		ene	
			1- State of Maryland / Department of Health and M		2005	02025
				2. Date of Death	J. NoF- U U J	2 Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)	Month	Day Year	3. Time of Death
	/Medic		Michael Brian Hill	January	12, 2005	6:10 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
			Washington Adventist Hospital Takoma Park		Montgom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bird	hplace (State or Foreign ountry)
	Director			May 3, 1		ginia
	DC ,		Usual Residence of Decedent			40d Lasida Oibel Inside
	how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Ma	ct	MD Montgomery Takoma Park			1½ Yes 2 No
	th th	Director	10e. Street and Number 10f. Zip Code	109	g. Citizen of What Co	ountry?
	h wi	a	7401 New Hampshire Avenue Apt 604 20912		U.S.A.	
	eep ee	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	city Yes or No-	14. Race - Ame Black, Whit	
9	after or ite	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	nouri, oto.)		Black
03	72 hours after deeth with the Maryland Inaturel; or Itema 23a or 28a-f show dical Examiner must be notified at	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify:	Diagn
9	2 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	16	6b. Kind of Business	Industry
21	within 7 ene. then *r	pid	Elementary/Secondary (0-12) College (1-4or 5+)	,9		
21	d wit	PO	2 Laborer		Privat	:e
ğ	be filed within 72 hours after deeth with the Marylan stal Hygiene. ed other then "naturel; or iteme 23a or 28a-f show event, It a Medical Examiner must be notified at	a	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
a	should be nd Mental marked o	To B	Eddie Lee Hill Jr Clar	ice Brool	ks	
Maryland 21215-0036	nd 2 should Ith and Meni		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	l Route Number, (City or Town, State,	Zip Code) 20912
	and 2 ealth a m 27 ls		Shaun L. Hill - Daughter 7401 New Hampshire A			
5					Oc. Location - City or	
Baltimore,	permit. Pages 1 Department of F Importent: If Ite any injury or ot once.		LESsurial 2 Cremation 3 Chemoval from State	/2005 1	Brentwood,	MD
틒	rtme rteni		^4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 1/19 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort	the second secon		
Ba	Depa mpo nny i		3401 Bladensburg Ro			
_	40.200					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	respiratory arres	ι,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition Chronic Renal Failure			
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions b. Seizure Disorder			
		ner	Sequentially list conditions, if any, leading to immediate gauge. E.f. of Uniformity Due to (or as a consequence of):			
1	outec	Examine	Cause (Disease or injury that initiated events			
oʻ	be executed sicien and burial-transit		resulting in death) Last Due to (or as a consequence of):			
68760,	<u>w</u>	cai	d			
68	leath certifical attending phy I for use as th	edi				
XO	andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	ivery
m	Jeath a atte	Cla	in the past 12 months? 1		Month	Day Year
0	at the de by the tached	ys	9 □Unknown			
Δ.	ge eg		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	icco use contribute to	the cause of death?
Records,	uires sign	d by		1 ☐ Yes	2 No 3 P	obably 4x Unknown
0	w requ been should	ete		040 1460	045 14/	Annu dindina audaha
ec	has h	idu		24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of
=	The law cate has page 2	Completed		1 ☐ Yes 2		2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical axaminer?	(Check only one,)	
of \	hysic this o	၉		me 5 🗆 Residen	ce 6 □Other (Spe	city)
		:uC	27. Manner of Death 1 St Natural 5 Pending (Month, Day Year) 28b. Time of lnjury 28b. Time of lnjury work?	28d. Describe how	injury occurred	
0	Attendia death. ctor: Ai y the fu	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	N or Attending efter death. Director: After d in by the fune	tif fic	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Ri State)	ıral Route Number,
D	s effer ei Direc ed in by	Certification	Salaria (Specific			
	hour hour mer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			
	To the Hospital o within 24 hours eff To the Funerel Di completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	od at the time, dat	e and place, and due	to the cause(s)
	Withii To tl	Ž	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mont	h, Day, Year)
	1		James lemmently traftfort h. M.D 52326		January 2	4, 2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-	
	9			koma Par	k MD	
	Sta	ato		Lar		
	Regist		31. Date filed (Month, Day, Year) FFB 0 3 2005 Registrar's Signature			
	9.01	9	LEO A O TOAR TOWN			

			For State Registrar	State of M	1arylar	nd / Depa	rtment of I	Health and Death		giene2 ()	05	030	26
	Physic		1. Decedent's Name (First, Middle, La Angela Marie H		-				2. Date of Dea Month January	ath Day	Year 05	3. Time of De 0045	
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and number	r)			or Location of Deat		4c. County	of Death		
	Funeral Director		5. Social Security Number 5. S 5.			last birthday) 5 Yrs.	Bethese If Under 1 Year Months Days	If Under 24 Hrs		Montg h, Year) 6, 1929	9. Birthp	y place (State or Fo itry) ington,	oreign DC
	death with the Maryland ms 23e or 28e-f show rmst be redified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	erv		y, Town or Lo	eation					0d. Inside City L	imits
	with the 3e or 28e	I Direc	10e. Street and Number 7620 Old Georget			chesua	10f. Zip Code 20814			10g. Citizen of W		ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Heatlh and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be redified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	t Ever in U. ? No	If		Hispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	United 14. Race Black Specify:	- Americ k, White, e	an Indian, etc.	
21215-0	d within 72 ho giene. er then "netur The Medicel	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or	5+)	(Give) lite. D	O NOT use retire	during most of wor	-		siness/Ind	dustry nstitute	es
ryland	chould be file of Mental Hy, marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) Emmett Leo Sheeh 19a. Informant's Name/Relationship (an				18. Mother's Nan	ne (First, Middle, e Marguer	Maiden Sumame	e) kins		
Baltimore, Maryland 21215-0036	iges 1 and 2 s nt of Health an f item 27 is or other treu		Susan Elizabeth 20a. Method of Disposition	Yore/Daugl	20h P	6057		Court, Ne	w Market Date Cuary 5		and	21774	
Baltin	permit. Pa Departmer Importent any injury once.		4 Donation 5 Other (Specify 21. Signature Hand Service Licer	Serve.	M008	03 Be	Name and Addre thesda-(thesda.	ss of Facility Ro Chevy Cha Maryland	hert A. ise, Inc. 20814-	7557 W	v Fur	neral Ho	ome/ ≥nue
	Prysician /Medical		23a. Part1. Enter the disease, or composition, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	e Res	n. Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Deat Days	n
¥ 8760,	death certificate be executed as the estending physician and and for use as the burral-transit and the control of the control	dical Examiner	Sequentially list conditions, "ary, teaching to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		erich:	ia coli	Sepsis					2455-70	
0045	death certifii e attending p d for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 1	Ectopic pregnancy Other <i>(specify)</i>			23d. Date Mont		y Day Year	
31/c	v requires that the been signed by th should be detache		Part II. Other significant conditions of Coagulopathy	ontributing to death b	out not resu	ulting in the und	derlying cause give	en in Part I.		pacco use contrib es 2 X No 3			
gela 1 Vital Reco	The law ate has b page 2 sl	Completed by	Aortic Stenosis Acute Renal Fail	ıre					24a. Was a autops perform 1 Yes 2	y pri ned? de	ior to com ath?	sy findings avail pletion of cause	able of
3 2	hys his l	To B	27. Manner of Death 1. X Natural 5 ☐ Pending	Hospital: 1 📉 Inpation 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IIV	ER/Outpatient 28b. Time of Injury	28c. Injury Work	^{er:} 4 □ Nursing Ho / at k?	th (Check only only only only only only only only	ence 6 Other	(Specify)		
Hughes, P. Division	teat feat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		jury - At hor tc. (Specify	me, farm, stree)		Yes 2 □ No	28f. Location (Str City or Town	reet and Number ı, State)	or Rural	Route Number,	
Hug	Hospi 4 hou Funer ely fill		29a. Certifier (Check only one) \[\begin{align*} \times	/sician: To the best iner: On the basis o and manner st	i examinati	vledge, death of inve	occurred at the tim stigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manr ate and place, an	ner as stat d due to t	ted. he cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MD			29c. License D006			anuary 3			
	1		30. Name and address of person who c Eric J. Park, M.I				int)	, Rockvi			20850		
	Stat Registra	_	31. Date filed (Month, Day, Year) FFB 0 3 200	32 3 enistr	ar's Signat	ure	1				-		

			For State	State of M	laryland		artment of H tificate of I		ind Mei	, ,	200	£,	02027
			Registrar 1. Decedent's Name (First, Middle, La	st)			lineate of t	Jeani	2.	Date of Death	g. Ná U U	<u> </u>	3. Time of Death
П	Physici		Frederick Vaso							Month		ear 5	7:40 A ^M
	/Medic Examin		4a. Facility Name (If not institution, giv)		4b. City, Town, or	Location of		andary	4c. County of		7.40
	LAGITI		Shady Grove Adv	entist Hos	spital	L	Rockvi	.11e			Montg	omen	су
	Funeral		5. Social Security Number 6. S	ex 7. Ao ☑M 2☐F	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2	Min. 8.	Date of Birth (Month, Day,	Year) 9	. Birthpl	ace (State or Foreign
	Director		367-18-1314	LOS M ZUF	86	Yrs.			AŢ	oril 22,	1918	Micl	hagan
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	Many -f sh	ţō	Vermont Rutland		Pa	awlet						Ì	1 ☐ Yes 2 反 No
	r 28a	lrec	10e. Street and Number			Wilce	10f. Zip Code			10	g. Citizen of Wha	at Count	try?
	th with	Funeral Director	137 Green Hill Ro	ad			05761				United	Sta	ates
	ems	ner	11. Marital Status	12. Was Decedent Armed Forces			Was Decedent of H	ispanic Orig	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race -	America White, e	
36	orlt	by Fu	1 Never Married 2 Married	1 Tyes 2 If Yes, Give	No WWI	I .	I ☐ Yes 21 No	Specify:			Specify:		hite
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alsal Examble must be mallisd at	ed b	3 ☐ Widowed 4 反 Divorced	Year or Dates:		16a Decer	lent's Usual Occupa	ation		1	6b. Kind of Busin	ness/Ind	uetny
21215-0036	n "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5.)	(Give	kind of work done of OO NOT use retired	during most	of working		oo. 14110 of 2001	10001110	astry
212	d within giene. er then "	E O	Elementary/Secondary (0-12)	5+	J+)		Physician	1			Health	Car	ce
2	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, If a Medical Examiner must be neitilised at	Be	17. Father's Name (First, Middle, Last,)				18. Mother	r's Name (F	irst, Middle, M	aiden Sumame)		
Maryland	should had marked marked	2	Frederick Christi							ese Pis			
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (. 1		g Address (Street a						ŕ
o,	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Rosina Hauser Pe	ertnei/Dau	20b. Pl	ace of Dispo	sition (Name of	T	Ve, P		Oc. Location - Cit		
ᅙ	Pages nent of I int: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		'∣Sai	int Jo	natory or other placeseph	1 P	ebrua , 200	ry p	Rutland,	Vor	mont
altimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licer	**	Rec	22	g Vault . Name and Addres	s of Facility	Rober	t A. P	umphrey	Fund	eral Home/
m	Per III De		4 A ROBE	Zens	M0135	66 Ro	ckville, ckville,	Inc. Marv1	300 Wand 2	est Mon 0850-28	tgomery 805	Ave	enue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death line.	. Do not ent	er the mode of dyin	g, such as c	ardiac or re	spiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	aspir	ation	2 0	neumon	iq					Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):		,					
	- Addition	J.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequi	ence of):							
	nted Insit	mine	cause. Enter Underlying Cause (Disease or injury	20010 (0. 00	a consoqu	01,00							
,	execting and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ience of):			· · · · · · · · · · · · · · · · · · ·				
8760	icate be executed physician and s the burial-transit	edical	(d									
9			IF FEMALE:										
Вох	death certific e attending pi d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy				23d. Date of Month		y Day Year
0	0 0	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of de	eath 5∟	Other (specify)						
مـ	The law requires that the te has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions of	contributing to death I	but not resu	Iting in the u	nderlying cause give	en in Part I.		23e. Did toba	icco use contribu	ite to the	e cause of death?
rds	quires n sigr uld be	d by								1 ☐ Yes	2×2No 31	Proba	ibly 4 Unknown
Records,	aw require s been sig 2 should t	Completed							[24a. Was an	24b. We	re autop	sy findings available
Ä	hysician: The law his certificate has E I director, page 2 s	mo								autopsy performe	ed? dea	th?	pletion of cause of
Vital	ian: artifica ctor.	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only one			
>	Physic this ce al dire	To I	1 ☐ Yes 2/5 No	Hospital: Inpati		ER/Outpatien		4 🗀 INUI:			ce 6 Other	(Specify))
Division of	ding P	lon:	27. Manner of Death DENatural 5 Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injun Work	≀at <br Yes 2. □N		. Describe how	injury occurred		
<u>s</u>	r Attencer death rector; by the	licat	2 Accident investigatio 3 Suicide 6 Could not b		iurv - At hor	me, farm, str	eet, factory, office	192 5 14		Location (Stre	et and Number	or Rural	Route Number
<u>></u>	after after Dire	Certification:	4 Homicide determined	building, e	tc. (Specify,)	501, 140101), 511100			City or Town,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.		29a. Certifier Certifying Ph	ysicien: To the best	of my know	vledge, death	occurred at the time	ne, date and	place, and	due to the cau	ise(s) and mann	er as sta	ited.
	the H the F nplete	Medical	one)	and manner s	tated.	on and/or in			T OCCUITED 2				
	ちずらら	2	29b. Signature and title of certifier Plus J	Mistor	N	10	29c. License				d. Date signed (A		
	1					00-) (T		738		J		1 00	7,2005
	v		30. Name and address of person who Alicia T. Misl		death (Item	ech Co	Print) Center	Dru	ve Re	ockril	le, mo) ス	10850
	Sta	tė	31. Date filed (Month, Day, Year)	1									
	Registr		FEB 03	2005	SEU5.	J.	Grade)						

			For	State of Maryland				Mental Hy	/giene	005	02020
			State Registrar Decedent's Name (First, Middle, Last)) ,	Certific	ate of L	Death	2. Date of D	Reg. No.	JU3	3. Time of Death
	Physici /Medio		SAMUEL	Harris				Janua	ry 29,	2005	2:40p M
	Examir	er	42 Facility Name (If not institution, give	eral Hospita	21 3	altin	Location of Death	+1/		ounty of Death	
	Funeral Director		010 10 1070	TM OFF	6 Yrs. Mon	ths Days	Hours Min.	8/Date of B (Month, D	rth ay, Year) 8-48	9. Birth Cou	place (State or Foreign intry) RYLAND
	death with the Maryland ms 23a or 28s-f show front to rediffed at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	the Ma	Director	Mol. 10e. Street and Number	1	Baltin	Zip Code		-	10g. Citize	n of What Cou	
()	23a or	ralDl	1503 E 33	ed Street					(151	7
His	fter de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No		. /	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14.	Race - Ameri Black, White,	
200	72 hours efter death with the Marylan "natural", or itams 23a or 28e-f show olical Examiner: sust be motified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		s 2 No	Specify:			pecify: BL	acr
1215-	⊆	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		Usual Occupa of work done d OT use retired,	luring most of worl	king		of Business/Ir	c Store
nd 2	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Item 27 is marked other than " other traumatic event, ILA M.	Be Co	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam	e (First, Middle	e, Maiden Su	ımame)	
ELanylan	should be and Mental Is marked o	2	5 AMUEL 9 19a. Informant's Name/Relationship (T)	Print(A:0A	19b. Mailing Add	ress (Street a	MAIN	CRIN V		OWN State Zi	
Ma,	1 and 2 s Heelth an em 27 ls ther trau		VIRGINIA GRE	y mother	1503	E	33 Rd	Stre	et	Balto	1 1 1
	90=0		20a. Method of Disposition 1	Removal from State	nce of Disposition of metery, crematory Race of 1	(Name of or other place	3-5	Date 0.5	Rock	tion - City or T	own, State
SAD	permit. Fag Di partment In portant: a. y injury o		21. Signature of Funeral Sovice Licens			e and Addres	s of Facility /6	39 N.	BROS	edura	y Butto
<i>y</i>	205 8 9		23a Part1. Enter the disease, of compl	ications that caused the death.	Do not enter the	mode of dvino	Methodo s, such as cardiac	or respiratory	arrest.	apel'	P.C 21213 Approximate
	Physician		23a part1. Enter the disease, of compleshock, or heart failure that only of Immediate Cause (Final disease or condition	ne cause on each line,	Shock						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
ć.	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
8760,	cate be physicia the bu	dical		d							
Box 6	h certifi ending r use as	an/Me	23b. was decedent pregnant	23c. If yes, outcome of pregnan		ic pregnancy			230	f. Date of deliv	,
P.O.	that the death certific ed by the attending pl detached for use as t	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of dea 9☐Unknown						Month	Day Year
	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the		Part II. Other significant conditions con FM SHAR VEY	ntributing to death/but not result	ting in the underlyin	ng cause give	n in Part I.		tobacco use		he cause of death?
Divislon of Vital Records,	aw requ s been 2 should	Completed by	And Clarge North	al forial C,	DIGIDETE	<u> </u>		24a. Wa	san 2	24b. Were auto	ppsy findings available
al Re	sician: The law certificate has t irector, page 2 s							auto perf 1 Yes	ormed?	prior to co death? 1 ☐ Yes	mpletion of cause of 2 No
Zij	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	R/Outpatient 3	Othe	26. Place of Dear			7015 (0	
1 0	g Phy er this eral d	H :	27. Manner of Death		28b. Time of Injury	DOA 28c. Injury Work	4 LI Nursing Ho	28d. Describe			(y)
islor	ttendin death. stor: Af	catlc	1	28e. Place of Injury - At hon	М	1 🗆 Y	es 2□No	29f Location	(Stant and A	humbor or Cur	al Route Number.
Div	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide determined	building, etc. (Specify)	ne, iann, street, iac	ctory, office			wn, State)	arriber of Hara	ar nodie Nuriber,
	s Hospi 24 hou s Funer etely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death occur on and/or investiga	rred at the tim ition, in my op	e, date and place, inion, death occur	and due to the red at the time	cause(s) an date and pla	d manner as s ace, and due t	stated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of Sertiller	>		29c. License	number 005	2/	29d. Date s	igned (Month,	/
	2		36. Name an address of person who co	ompleted cause of death_(Item 2	23a) (Type, Print)	1	840%	10	01/	1.	2005
_	0		justavo (or	rales Mo), (10)	Mary	1and G	iener	a/H	OSP11	7
	Sta Registr	4	Ti. Date filed (Month, Day, Year) FEB 0 3 2005	32. Registrar's Signatu	greates.	/				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 8840 2-9-05 vt
State of Maryland Phepartment of Health and Mental Hygiene 0 0 5 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ALBERT JOHNSON Tanuary 28,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Baltmore L'TT If Under 1 Year If Under 24 Hrs. NIA Age (In yrs. last birthday) 5. S220°74°1360 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 5 Months Days Hours Min. AUG. 16, 1959 MARYL Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits injury or other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 82 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23s any Injury or other traumatic evant. NORTH 121 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No by Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2+HGRADE MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 W. NORTH AVE. BALTO, HO. 2/217

Date 20c. Location - City or Town, State JEANNETTE JOHNSON (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₽ Burial 2 Cremation 3 Removal from State ARBUTUS CEMETERY 02-04-05 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative of Fune I Service Licensee 22. Name and Address of Facility BROWN 2945 DIFFULTON AVE BROWN JR. FUNERAL HOME BALTO.MD.21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Purulent Meningitis Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Bronchopneumonia burial-transit Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy O in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1/☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Box 68760. Division of Vital Records, P.O. To the Hospital or Attanding Physician:

the attending physician

signed by

has

certificate

this

within 24 hours after death. To the Funeral Director: After

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of

Baltimore,

or 28e-f show

Registrar DHMH 17 Rev 1/2001

ORIGINAL

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Gitneral Hospita

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 03030 AMEND ITEM #7 PER FII G840 2/03/05 TH 2. Date of Death 3. Time of Death Johnson **Physician** John 2:50 AN JANUARY 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 213 18 7238 1**23**M 2□F Days 82 Yrs. 83 maryland Director 10/08/1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic svent, the Medical Examinar - ust be notified at Baltimore 1 Yes 2 No maryland Directo MA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S.A 1213 Roland Heights Ave 21211 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 No 942 -If Yes, Give 1942 -Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced 1944 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Casperter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should ba f n and Mantal H Is marked of Johnson Fred 2 NA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. John son 1213 Roland Heights Ave Balto, M.D. Gregory L 20a. Method of Disposition San or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M2 Cremation 3 ☐ Removal from State permit. Paga Department c Important: If any injury or 2/2/05 Baltimore greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility Into 9 cdy Funeral Support 21. Signature of Funeral Service Licensee 119-1218, Stricker St. Balto mo 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) olymicrobial Physician /Medical Due to (or as a consequence of). 2 weeks **Examiner** Empyema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of) Examiner burial-tran Due to (or as a consequence of): nding physician Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ Month 1 ☐ Yes 2 ☐ No signed by the Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Frobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 2 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending Injury er death. rector: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE E RAMSE SINAL DOVGLAI MI 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 2005

DHMH 17 Rev 1/2001

Registrar

Known

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician FEBRUARY** 2005 12:45 A M **JOLLES JEANNETTE** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LORIEN NURSING HOME COLUMBIA HOWARD If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV . 6, 1922 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 🙀 F 122-26-5952 82 FRANCE Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County , or Itame 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No **COLUMBIA** MD HOWARD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10001 WINDSTREAM DRIVE #703 21044 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? e filed within 72 hours after it Hygiane. other then "natural", or Ital 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 2 3 Widowed 4 Divorced Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CUSTOMER SERVICE REP. AIR FRANCE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be fili partment of Health and Mental Hy portant: If Itam 27 is marked oth y Injury or other treumatic event Be (UNKNOWN) TOUANON JEANNE ARTHUR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10001 WINDSTREAM DRIVE #703 - COLUMBIA, MD 21044 SAMUEL JOLLES / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Important: If any Injury or COLUMBIA MEMORIAL PARK 2/3/2005 COLUMBIA, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 18900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) arcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗆 No 3 ☐ Probably 4 🔁 Onknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 this certificate 2-XNo 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) director Be 25. Was case referred to medical examiner? Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title oncertifier 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River Necle 201-190 HMCOOI 1A1216 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 03 Registrar

			1_ For Amend Item 23	State of Maryla a per Dr., G					_	· 5 0000
			Registrar 1. Decedent's Name (First, Middle, Last		061	uncate	UI DeallI	2. Date of Death		0 43432
	Physic		Leonard Lee	Johnson				Month	Day Yea	M
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City. Toy	vn, or Location of Death	January	27, 200	
	-Adilli	3	Greater Baltimor		nter	,, -	Towson			timore
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yr	s. last birthday)	If Under 1 Y	ear If Under 24 Hrs.			Birthplace (State or Foreign Country)
	Director		210-20-1394	XM 2□F 72	Yrs.	Months D	ays Hours Min.	(Month, Day, April 3,		Baltimore
	and w		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	nation				
	Aaryli aho	5	,							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
73	28a-	Director	MD Baltimo	re	Reister	10f. Zip Co	do	10	- 0141	
7	With Sa or			ov Cirolo		TOT. ZIP CO		10	g. Citizen of What	
Ponanc 036	death with the Maryland ms 23a or 28a-f ahow	lera	4 Franklin Valle	12. Was Decedent Ever in	U.S. 13. V	Vas Decedent	of Hispanic Origin? (Sc	ectly Yes or No-		JSA merican Indian,
50	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give			of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	Black, Wi	
} € 0 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ours ours	d by	3 XWidowed 4 ☐ Divorced		ean	☐Yes 2【X	.No Specify:		Specify:	White
7	72 h 'natu	Completed by Funeral	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Or	ccupation one during most of work	una 1	6b. Kind of Busines	ss/Industry
⁻ 121	ed within rgiene. er than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	OO NOT use re	etired)			
9 B	Hygie Hygie other i		17. Father's Name (First, Middle, Last)		Di	spatch		e (First, Middle, M.	Oil Cor	npany
150 land	Mental Mental arked o	9 Be	Harry Johnson					e <i>(riisi, middi</i> e, <i>m</i> . Badenbaum	,	
<u>₹</u> ₹	2 should and Mer is marke	2	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailin	n Address (St	reet and Number or Rui			Zin Cadal
\ OE	01 00 = 0			•						
Baltimore,	es 1 and 2 of Health fitam 27 rother tra		Dorothea A. Crumba 20a. Method of Disposition	206.	Place of Dispos	ition (Name o	1		Cerstown . Dc. Location - City o	
Ě	Pages nent of I nnt: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		cemetery, crem arro11 C		1	1/05	Homeson	MD Loc
盖	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License				ddress of Facility		Hampste eistersto	
ñ	Depa Impo any is		Sam BO	e Comment	E1	ine Fu	neral Home		stown, MI	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea						Approximate
	Physician	L	Immediate Cause (Final disease or condition	CARDIAC	AK	PREST				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						DAVE
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse						D/T/J
	ocuted nd transi	Examiner	that initiated events	Renal Fail	ure					
760,	tte be executed lysicien and ne burial-transit		resulting in death) Last	Due to (or as a conse	quence of);					
87	9 % 9	dicai		_Congestive	Heart 1	ailure				
W 88	Attending Physician: The law requires that the death certifica redath. Indeath. Inde	Physician/Med	IF FEMALE:	So If you system of any						1
Box &	attend for us	ian	in the past 12 months?	3c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of	aldeath 3∏£	Ectopic pregna			23d. Date of di Month	elivery Day Year
o.	that the di ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	death 5LJ	Other (specify	"/			July 1 July
Δ.	that the	y Ph	Part II. Other significant conditions con	tnbuting to death but not re	sulting in the und	derlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of dealh?
rds	quires n sign uld be	d by								robably 4 \Quad Unknown
0	s been si should	Completed						24a. Was an	24h Wara a	utopsy findings available
Re	The lavate has page 2	mo						autopsy performe	d? prior to death?	completion of cause of
ita	ician: Th certificate ector, pag	0	25. Was case referred to medical				26 Place of Death	1 Yes 22 (Check only one)	⊈ No 1 □ Ye	s 2 No
>	nysici, nis cer direci	ТоВ	examiner? 1 ☐ Yes 2 🗹 No	ospital: 1 Tnpatient 2	ER/Outpatient	3□ DOA	Other		e 6 □Other (Spi	acity)
0	ding Ph J. After th funeral		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lr		28d. Describe how		
Sio	Attendia death. ctor: A y the fu	catic	2 ☐ Accident investigation	,	,,		☐Yes 2☐No			
Division of Vital Records,	l or Attendatter deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree	et, factory, offic	Ce	28f. Location (Stree City or Town, S	et and Number or R State)	lural Route Number,
	Hospital or 14 hours affer Funeral Dir 16ly filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death	occurred at the	e time, date and place,	and due to the caus	se(s) and manner a	s stated
4	To the Hospital or within 24 hours after To the Funeral Diracompletely filled in b	edical	one)	er: On the basis of examination and manner stated.	ation and/or inve	estigation, in m	y opinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	Vitt To Con	Σ	29b. Signature and title of certifier	MD		29c. Lice	ense number	29d	Date signed (Mon	th, Day, Year)
			Fromesz Pajak			DU	1773		12/105	
			30. Name and address of person who cor	mpleted cause of death (Ite	m 23a) ype, Pr		MOIFE &	BA	LTIMO	0 - 91104
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	I	1 01	THE CHILD OF	NA	-171701	CT alary
F-1	Registr		FEB 0 3 2005 A	reser to A	barte					

			State of N	laryland / De			lental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of I	Death	2. Date of Deatl	9. NG. UU	5 03033
	Physic		Thelma	Willie	J	ohnson	Month Januar	_	3. Time of Death 005 3:30p.M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death	04.1442	4c. County of	1
			Gilchrist Nursing Home		Towson				imore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. A	ge (<i>In yrs. last birthd</i> a 91 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04 16	Year) 12	Birthplace (State or Foreign Country)
			Usual Residence of Decedent				04 16	13	SC
	anylan show	_	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits
	he Ma 28a-1	Director	MD NA 10e. Street and Number	Baltim					1 XYes 2 No
	with a sor 3	급	3319 Ludgate Road		10f. Zip Code	215	10	g. Citizen of Wha	at Country?
	death ms 2:	Funeral	11. Marital Status 12. Was Deceden	Ever in U.S. 13	3. Was Decedent of Hill Yes, specify Cuba		ecify Yes or No-		American Indian,
99	be filed within 72 hours after death with fhe Maryland ata Hygiene. A provided of other than "natural", or itams 23a or 28a-f show avant, the Marcical Examples in 1981 be notified at	/Fui	Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc.
$\frac{\partial \mathcal{S}}{\partial \mathcal{D}}$ Baltimore, Maryland 21215-0036	hours tural',	ed by	**XVidowed 4 Divorced Year or Dates:	10- 0-				Specify:	Black
715	nin 72 n "na n oc	plet	15. Decedent's Education (Specify only highest grade completed) _Elementary/Secondary (0-12)	(Giv	cedent's Usual Occupa ve kind of work done o . DO NOT use retired	during most of worki	ng 1	6b. Kind of Busin	ness/Industry
212	2 should be filed within and Mental Hygiene. Is marked othar than "sumatic avant, Ite Mes	Completed	Elementary/Secondary (0-12) 12th grade College (1-4or 2yrs	5+)	Nursing			Privat	e Duty
pu	be filed ttal Hygie d othar avant, II	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)	
Z Na Na Na	should be ind Mental imarked c	To	George Parks			Arrah G			
S S	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av once.		19a. Informant's Name/Relationship (Type, Print)		iling Address <i>(Street a</i> .9 Ludgat				
<u>ə</u>	S 1 ar f Hea itam othar		Jan Terry-Daughter 20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place			Oc. Location - City	
c ji	Page nent c		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		emorial P		/05	Dandall	stown, Md
Salt	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee		22 Name and Addres March F/	s of Eacility	700	diidall	SCOWII, Ma
10	905 g		Tala Warch	_	4300 Wab	ash Ave	, Balti	more,	Md 21215
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	d the death. Do not e ine.	Λ		r respiratory arres	st,	Approximate Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a consequence of):	dement	ra			Hears
200	Examiner			a consequence or,					
0)	р ;	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
53	ecute and I-trans	Examiner	that initiated events	a consequence of):					
lan	icate be executed physician and the burial-transit	alE	Due to (of as	a consequence on).					
68	The law requires that the death certificate be executed to has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	ledical	d						
Box	leath certiff attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth		□Ectopic pregnancy			23d. Date of	delivery
30.	that the death	sici	in the past 12 months? 1 Yes 2 No 4 Pregnant a 9 Unknown 9 Unknown	t time of death 5	Other (specify)			Month	Day Year
20	es that if igned by be detac	Phy	Part II. Other significant conditions contributing to death to	ut not resulting in the	underiving cause give	n in Part I	23e. Did toba	cco use contribut	te to the cause of death?
The ords,	w requires been sign should be	Completed by	Urinay tract interer				1 ☐ Yes	. /	Probably 4 Unknown
000	law requas been 2 should	plete	V				24a. Was an	24b. Were	autopsy findings available
$\mathcal{M}\mathcal{M}_{i}$		Com					autopsy perform∉ 1 ☐ Yes 2	_ prior	to completion of cause of h?
7)X	Physician: this certific	Be	25. Was case referred to medical examiner?			26. Place of Death			- 1
4 5	d is	To	1 Yes 2 16 Hospital: 1 Inpatie			4 LI Nursing Hor			Specify) HOSPICE
- io	Attanding or death. actor: After by the fune	atlon	27. Manner of Death 1	y Year) Injury	Work*	es 2 □No	8d. Describe how	injury occurred	*
Division	r Attandi er death. ractor: A by the fu	Certification:	3 □ Suicide 6 □ Could not be	ury - At home, farm, s	treet, factory, office	2	8f. Location (Stree City or Town,	et and Number or	r Rural Route Number,
۵	oital o urs aft iral Di	Cer						_ ′	
	To the Hospital or Attanding Ph within 24 hours afler death. To the Funaral Diractor: Atter th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	i exa <i>m</i> ination and/or ii	th occurred at the time nvestigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	se(s) and manner and place, and	r as stated. due to the cause(s)
	Fo the within Fo the comple		29b. Signature and title of centifier	Attendin	29c. License			. Date signed (Me	
	2 7 - 0		Tans by	Physician	Hospica DO	05745	9	1/29/0	5
_	n,		30. Name and address of person who completed cause of c	eath (Item 23a) (Type	, Pont)	0	10	1 1 1 1	- h 0
	3		DAVIO BEKELMAN MO 31. Date filed (Month, Day, Year) 32. Regist	(C 6 0) Ar's Signature	1). (h	arles	H. 154	L) Imos	E IN V
	Star Registra		FEB 0 3 2005 D	and Signature	A Miller				21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry J. Jackson Jr. ANUARY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BAUTIMORE 05 BALTIMORE If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. Nonth Day, Year Of 46 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**) M 2□ F 218-44-7800 58 **Director** other known as Jackson, Harry Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Medical Exact tree must be notified at Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3738 Park Heights Ave or Items 23e 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Cab Driver Royal Cab Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental F Harry J. Jackson Sr. Mary Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Rosalita Stone'-Jackson 3738 Park Heights Ave, Balto, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 2/5/05 Arbutus, Md `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. LEBSIELLA Immediate Cause (Final PNEUMONIA Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obesit 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, of Vital Division To the Hospital or Attending death. after within 24 hours a To the Funerel I

2 **X**No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of gertifier

29c. License number RES-000

29d. Date signed (Month, Day, Year) JANUARY 31, 2005

3. Time of Death

Birthplace (State or Foreign Country)
 MD

Black

21215

21215

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits

1 XYes 2 No

Year

person who completed cause of death (Item 23a) (Type, Print) RAMSEY MID SINAL

HOSPITAL OF BALTIMONE

State Registrar

Be

2

Certification:

Medical

After

Director:

2005 32. Registrar's Signature

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Specify:

Own Home

Reg. No. 005

2005

Montgomery

1952 British

4c. County of Death

10g. Citizen of What Country?

United States

Race - American Indian, Black, White, etc.

Black

1711

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🛣 No

31,

2. Date of Death Month

January

8. Date of Birth (Month, Day, Year)

16,

17. Father's Name (First, Middle, Last)

Ezekial Webb

Eunice Powell

Completed

the Medical

s 1 and 2 should be fill thealth and Mental Hitem 27 is marked ottother traumatic even

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

burial-tran

attending physician I for use as the buria

signed by the a

should peen

page 2

funeral director,

in by

filled 24 hours a

this

rector:

within 2

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examine

Physician/Medical

Completed by

Be

2

Certification;

Medical

State

Registrar

19a. Informant's Name/Relationship (Type, Print)

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kettly A. Jefferson / Husband 298 Hermon Hill, Christiansted, St. Croix,Virgin Island Date 20c. Location - City or Town, State

February 12, 2005

18. Mother's Name (First, Middle, Maiden Surname)

1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Kings Hill Cemetery

Homemaker

Fredericksted, St. Croix Home/

11 Cemetery 12, 2005 U.S. Virgin Island
22 Name and Address of Facility Robert A. Pumphrey Funeral F
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 Rockville, Inc. Rockville, Mary M00335 23a. Part1. Enter the disease, or consolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Embolism

Approximate Interval Retween Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months? ☐ Yes 2 No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy

23d. Date of delivery

9 Unknown

9 Unknown

5 Other (specify)

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diabetic Ketosis Acidosis

<u>Diabetes Mellitus</u>

. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 2XXVo

24a. Was an autopsy performed? Yes 2 No 1 Yes

26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case relerred to medical examiner? 2 No 1 Tes 27. Manner of Death

1 Matural

2 Accident

3 Suicide

(Check only one)

Hospital: 1 Inpatient 5 Pending investigation

2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and tiple of certifier

29c. License number

29d. Date signed (Month, Day, Year)

10

D0061856

February 1, 2005

Heather Correction M.D.

31. Date filed (Month, Day, Year) FEB 03

32, egistrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

9901 Medical Center Drive Rockville, Maryland 20855

Physician /Medical Examiner 4a. Factor of Health and Mental Hygiene 1 and 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene 2 and 1 a	cial Security Number 6.5 0-26-3392 Residence of Decedent State 10b. County Howar Street and Number 95 Cedar Lan arital Status Never Married 2 Married Widowed 4 Divorced 15. Decedent's E (Specify only highest gr. mentary/Secondary (0-12) 12 ather's Name (First, Middle, Last	ive street and number) Cond Mcd Six 7. Age 1	10c. City, Town or C o 1 um b	DA Inday If Under 1 Yea Months Days or Location bia 10f. Zip Code 2 13. Was Decedent of If Yes, specify Cul 1 Yes 2 No Recedent's Usual Occupation Custod Custod Aailing Address (Stree	1044 (Hispanic Origin? (Johan, Mexican, Pue o Specify: upation e during most of we red) 18. Mother's Na Flore:	(Specify Yes or Normal Rican, etc.)	Day Year Year 1200 14c. County of Deal Roll NYD 15c. NYD	thin the CITY and the City Limits ary Land 10d. Inside City Limits 1 12 Yes 2 10 No ountry? Think to the City Limits 1 12 Yes 2 10 No ountry? Think to the City Limits 12 Yes 2 10 No ountry? Think to the City Limits 12 Yes 2 10 No ountry?
2 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10 Section 10	cial Security Number 0 - 26 - 3392 Residence of Decedent State 10b. County Howar Howar Street and Number 95 Cedar Lan arital Status Never Married 2 Married Widowed 4 Divorced Specify only highest grammentary/Secondary (0-12) ather's Name (First, Middle, Last alcolm B. Informant's Name/Relationship (eila Warner/ Method of Disposition Burial 2 Cremation 3 Donation 5 Other (Specifi	Sex 1 M 24 F 7. Age 1 M 24 F 7	10c. City, Town or C o 1 um b Ever in U.S. 1 16a. De (G) 1/6b. Place of Dis	If Under 1 Yea Months Days or Location bia 10f. Zip Code 2 13. Was Decedent of If Yes, specify Cul 1 Yes X No eccedent's Usual Occur Sive kind of work done fe. DO NOT use retin Custod	ar If Under 24 Hr Is Hours Min 1044 (Hispanic Origin? (Johan, Mexican, Pue) o Specify: upation e during most of wired in an 18. Mother's Na Flore:	(Specify Yes or North Rican, etc.) (Specify Yes or North Rican, etc.) orking H ame (First, Middle, M nce L. S	9. Bind Co Na 9. Citizen of What Co USA 14. Race - Ame Black, White Specify: B 16b. Kind of Business/ OWard Co- laiden Sumame) utton	Inplace (State or Foreign ountry) Iryland 10d. Inside City Limits 1 Ryes 2 No ountry? erican Indian, te, etc. lack //industry unty Scho
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or liems 23a or 28e-1 show admatic event, the Medical Evanther must be routhed at 10 marked other than "natural, or liems 23a or 28e-1 show admatic event, the Medical Evanther must be routhed at 12 marked other manual broad at 12 marked other manual properties. To Be Completed by Funeral Director and 18 marked other manual m	State 10b. County Howar Street and Number 95 Cedar Lan arital Status Never Married 2 Married Widowed 4 Divorced (Specify only highest gramentary/Secondary (0-12) 12 Stater's Name (First, Middle, Last alcolm B. Informant's Name/Relationship (eila Warner/Method of Disposition Beurial 2 Cremation 3 Donation 5 Other (Specify Donation 5 Center)	e #405 12. Was Decedent E Armed Forces? 1 □ Yes 2 ₹ N If Yes, Give Year or Dates: Education rade completed) College (1-4or 5- t) Winston (Type, Print) Daughter	Columb Ever in U.S. 1 No 16a. De (Griffe) 19b. Mar 1121 20b. Place of Dis	10f. Zip Code 2 13. Was Decedent of If Yes, specify Cul 1 Yes 2 No ecedent's Usual Cocu. Give kind of work done if the DO NOT use retire. Custod: Aailing Address (Stree	1 0 4 4 f Hispanic Origin? (Jahan, Mexican, Pue to Specify: upation be during most of we during most of we red) 1 a n 18. Mother's Na Flore:	(Specify Yes or No- and Rican, etc.) orking H ame (First, Middle, M nce L. S	USA 14. Race - Ame Black, White Specify: B 66. Kind of Business/ OWard Co- laiden Sumame) utton	1 RYes 2 No ountry? erican Indian, te, etc. lack /Industry unty Scho
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To Be C To Be	alcolm B. Informant's Name/Relationship (eila Warner/ Method of Disposition Burial 2 Cremation 3 C Donation 5 Other (Special	Winston (Type, Print) Daughter	20b. Place of Dis		Flore	nce L. S	utton	
She	Method of Disposition □ Burial 2 □ Cremation 3 □ □ Donation 5 □ Other (Specif	☐Removal from State	20b. Place of Dis					
Can		.NI ,	Meadowr	isposition (Name of crematory or other pla Cidge Cen	anche Wa	ay Colum	bia, MD : Oc. Location - City or 1 1kridge,	21044 Town, State
	Part1 Enter the disease, or comshock, or heart failure. List only	ensee day	F	22. Name and Addre	ress of Facility Ta th Capit	aylor's i	Funeral I NW Wash.	
/Medical diseas resulting transport of the first of the f	diate Cause (Final se or condition ing in death) entially list conditions, leading to immediate . Enter Underlying a (Disease or injury itlated events ing in death) Last	a. Seysi. Due to (or as a b. Due to (or as a c.						Interval Batween Onset and Death
ached for use as lacked for us	MALE: Was decedent pregnant in the past 12 months? □ Yes 2 □ No	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	2 Fetal death 3	3 □Ectopic pregnanc 5 □ Other (specify) □	зу		23d. Date of deliv	ivery Day Year
per equipment of the per equip	Other significant conditions of	ontributing to death but	it not resulting in the	e underlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
or, page 2	as case referred to medical				26 Place of De	24a. Was an autopsy performe 1 Yes 2)	prior to co death? No 1 \(\sum \text{Yes}\)	topsy findings available completion of cause of 2 No
After this funeral dilumeral dilumer	aminer? Yes 2 No Inner of Death Natural 5 Pending Accident investigation		y 28b. Time (Year) Injury	e of 28c. Injury Wor	her: 4 Nursing F iny at ork? Yes 2 No		ce 6 □Other (Speci	ify)
Funeral Director: After the fune stelly filled in by the fune dical Certification	Suicide 6 Could not be determined	building, etc.	of my knowledge dea	street, factory, office	ime, date and place	City or Town, S	(a)(a)	
nin the nple	check only 2 Medical Example one) 2 Medical Example one)	miner: On the basis of e and manner state	examination and/or i	29c. Licens	opinion, death occu	29d	se(s) and manner as seand place, and due to the signed (Month,	to the cause(s)
8 20	me and address of person who ache Sali KNI te filed (Month, Day, Year)		eath (Item 23a) (Type	oe, Print)	nmove,		1201	2005

		Please	State of Marylar			•	9	e.
		1 - State Registrar		Certific	ate of Death		Reg. Not	5 03037
Ph	ysician	1. Decedent's Name (First, Middle, L		-		2. Date of De	Day _ Y	3. Time of Death
	/ledical	A = = 100 Alexan 200 1 - 100 - 1	ouis Kelley	4h (City, Town, or Location of	Jehning Death	4c. County of	
Ex	amme	North Arundel			len Burnie		,	Arundel
Fun	eral	Social Security Number 6.	Sex 7. Age (In yrs.	last birthday) If Un	nder 1 Year If Under 2			Birthplace (State or Foreign Country)
Dire	ctor	574-10-2930 Usual Residence of Decedent	1\\ M 2□F 69	Yrs.	Sis Buys Tiours	MAY 30	, 1935	Iowa
arylan show	ē .	10a. State 10b. County		y, Town or Location				10d. Inside City Limits
We we	affile of of	Maryland Anne	Arundel		na Park			1 ☐ Yes 2 XNo
with t	d g	10e. Street and Number		10f.	Zip Code	9.00	10g. Citizen of Wha	it Country?
ms 23	Naminar must be oxtilled by Funeral Director	100 Park Plac	12. Was Decedent Ever in U	.S. 13. Was Do	21146	n? (Specify Yes or No	USA - 14. Race -	American Indian,
or Item		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 196		ecedent of Hispanic Original Specify Cuban, Mexican,	Puerto Rican, etc.)		White, etc.
5-0036 72 hours a	d by			1	s 2X No Specify:		Specify:	White
Ind 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or Items 23a or 28a-1 show	t. It's Madical F	15. Decedent's i (Specify only highest g	rade completed)	16a. Decedent's t	Jsual Occupation f work done during most of T use retired)	of working	16b. Kind of Busin	ess/Industry
212 od withi giene.	Me M	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +	Atto	· · · · · ·		Federa	l Government
A filed of the other	event.		st)	110001		s Name <i>(First, Middl</i> e,		- dovernmente
aryland should be file and Mental Hy s marked oth	atic e	Norbert Kell	еу		Не	len Chri	stianser	1
Maryland 2121: 2 should be filed within and Mental Hygiene.	any injury or other traumatic ODCE. TO	19a. Informant's Name/Relationship			ress (Street and Number			
5 = 2	thert	Daniel A. Kel		10155 15	Oth Street	East Ners		
Baltimore, permit. Pages 1 at Department of Heal	0	1 ☐ Burial 21 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of the Cont	Ti removal itom State	Place of Disposition (emetery, crematory	l I		20c. Location - Cit	
Iltin	in in in	21. Signature of Funeral Service Lice	,2100	ro Cremat	ory, Inc. 2	/2/05	Baltimo	ore. MD
Balt permit. Depart	any ir	Rayans A	Gregorchik	Cren	nation Soc	iety of	MD, Inc.	MD 21228
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	77	h. Do not enter the r	mode of dying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
Physic	ian	Immediate Cause (Final disease or condition	metanta	Air.	. 1	anar		Onset and Death
/Medi Exami		resulting in death)	Due to (or as a consequence	uence of):		10010		1
Exami		Sequentially list conditions,	b. Due to (or as a consequ	uenco of):				
\$\frac{1}{2}	ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter U Janying Cause (Disease or injury	bue to (or as a consequ	defice of).				
60, be execut	FXa	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of);				1
760 Ite be e	o princai		d.					
Box 68760, leath certificate be executed attending physician and	letached for use as the Physician/Medi	IF FEMALE:		-				
Box Bath cert	for us	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal	I death 3 □Ectopi	cpregnancy		23d. Date of Month	delivery Day Year
P.O. nat the de	ched	1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown	eath 5 🗌 Other	(specify)			,
	be deta		contributing to death but not resu	ulting in the underlyin	ng cause given in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
Vital Records, sician: The law requires the certificate has been signed	should b					1 U Y	'es 2□No 3□	Probably 4 Unknown
ecc lawre	Completed					24a. Was autop		autopsy findings available to completion of cause of
The The	Page					perfor	med? deat	h?
of Vital Rec Physician: The lav	Be Betor	25. Was case referred to medical examiner?	Hospital:		0.11		в	
this this	To To	1 Yes 2 No	1 npatient 2	ER/Outpatient 3 28b. Time of		ing Home 5 Resid	ence 6 Other (5	Specify)
On refing the	tion	1 Natural 5 Pending 2 Accident investigation	28a. Vate of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		ow injury occurred	
Division of a lor Attending Physical or Attending Physical Geath.	ed in by the tunera	3 Suicide 6 Could not lead to determine	1 28e. Place of injury - At no	me, farm, street, fac	tory, office	28f. Location (S	treet and Number o	r Rural Route Number,
Di Ital or Its after	Cert	T C TIONNOIS	building, etc. (Specify			City or Tow	n, State)	
Division (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After	completely filled in by the tuneral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occum ion and/or investigat	red at the time, date and lion, in my opinion, death	place, and due to the o occurred at the time, o	ause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the	Me Me	29b. Signature and title of certifier			29c. License number	2	29d. Date signed (M	onth, Day, Year)
	1	Action	כנות		043977	7	Jehn an	1205
	10	30. Name an addr s of person who	completed cause of death (Item	23a) (Type, Print)	2 //	0.		12a5 21061.
11	Curt	31. Date filed (Month, Day, Year)	3 Hegistr r's Sid au	Hay Ison	weilling	Suma-	mo a	2061.
Reg	State gistrar	FEB 0 3 20	09 Meyer A	goods	,			

State of Maryland / Department of Health and Mental Hygiene & Control Register / Department of Health And Mental Hygiene & Control Register / Department of Health And Mental Hygiene & Control Register / Department of				Please I	ype or Print in				•	_	ole.
December of fame street, Notes, Last Total Control				1 - For State Registrar	State of Maryla						05 03038
Control Cont				1. Decedent's Name (First, Middle, Last) JOSEPH J	Kluka				2. Date of De Month	Day 7 31 2	205 3:00 AM
Second Second American Second Second American Second		Examin	er	11 1 1/ 1/10/11		Conter			eath		of Death
16.0 State 16.0 County 1				5. Social Security Number 220–98–1653 15	7. Age (In yi		If Under 1 Year	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da MAY 15	th	9. Birthplace (State or Foreign Country) Maryland
State Column Co		Maryland a-f show	tor	10a. State 10b. County				cown			
State Column Co		or 284	Direc				10f. Zip Code	21122		10g. Citizen of W	•
State Column Co		ns 23s	eral			U.S. 13.	Was Decedent of H		(Specify Yes or No	- 14. Race	
State Column Co	036	ours after o rei', or iten Exemene			If Yes, Give				uerto Rican, etc.)		k, White, etc.
Physician Medical Examiner Physician International Control of the Control of	1215-0	within 72 ho ane. than "netu	mpleted	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work done DO NOT use retire	during most of	working		
Physician Medical Examiner Physician International Control of the Control of	d 2	Hygie other	e Co				N/ A	18. Mother's	Name (First, Middle,		
Physician Medical Examiner Physician International Control of the Control of	/lan	uld be Mental Irked	To B	Joseph Charles H	Cluka			Shar	on DeCour	cey	
Physician Medical Examiner Physician International Control of the Control of	, Mary	and 2 sho baith and I n 27 is me			ıka/father	4229	Wards Ch				
Physician Medical Examiner Physician International Control of the Control of	imore	Pages 1 ment of Hi ent: ff iter ury or oth		1 ☐ Burial 2 XCremation 3 ☐ R	emoval from State	cemetery, cre	matory or other pla				
Physician Medical Examiner Physician Medical Examiner Physician Medic	Balt	permit. Depart import any inj		21. Signature of Funeral Service License Dawn F. McDo	onald	2	cremation 299 Frede	ss Societ erick Ro	y of Mary oad Balti	land, In	nc. D 21228
Sequentially list conditions, and, making to immediate cause. Enter Underlying a cause of death? Sequentially list conditions, and, making to immediate cause. Enter Underlying a cause of death? Due to (or as a consequence of): C.			12200	shock, or heart failure. List only or Immediate Cause (Final disease or condition	le cause on each line.	ath. Do not en	er the mode of dyir				Approximate Interval Between Onset and Death
The state of the s	8760,	e be executed rsician and e burial-transit	cai	that initiated events	Due to (or as a conse	equence of):	ammetez	- Resp.	inse Syn	drue	843
The state of the s	Вох	the death certific y the attending p iched for use as	ysiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	tal death 3		/			
The state of the s		quires that in signed b uld be deta	ed by Pł	1	^		nderlying cause giv	ren in Part I.			
25. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred 28. Describe	Reco	The law reate has bee page 2 sho	ompiet	hipatitis B, H	odghins /4.	mp hom.			autop perfo	rmed? de	rior to completion of cause of eath?
State Stat	/ita	clen: ertifica ector,	a	examiner?							
State Stat	of	Physic rthis c ral dir		TEL TOS 2 NO	1 Minpatient 2		IL 3LI DOA	4 🗀 Nursin			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mathew Smith, M. D. 22 South Creine Street Bultimore, MD 21201 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ion	nding tth. r: After	atlon	1 ☑Natural 5 ☐ Pending	(Month, Day Yeer)		Wor	k?	204. 5000/150 /	iow injury occurre	u
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mathew Smith, M. D. 22 South Creine Street Bultimore, MD 21201 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Divis	el or Atter s after dea of Director	Sertifica	3 Suicide 6 Could not be	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office	-			r or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mathew Smith, M. D. 22 South Creine Street Bultimore, MD 21201 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		he Hospit in 24 hour he Funere	edical	(Check only 2 Medical Examin	1er: On the basis of examin	nowledge, deatl nation and/or in	occurred at the tirvestigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
Mathem Smith, M. D. 22 South Greene Street, Bultimore, MD 21201 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Withi To t	Σ	29b. Signature and title of certifier			29c. Licens	e number			
Mathem Smith, M. D. 22 South Greene Street, Bultimore, MD 21201 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	17		/ lawy	-00		71	6775		January	-31,2005
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1		Milling W.		em 23a) (Type, Creine	Street	Bultin	une, MD		
			-	31. Date filed (Month, Day, Year)		nature	74		,		

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Marylan						•
			1 - State Registrar		Cer	tificate of	Death		. No. 200	5 03039
6	Physici /Medi	cal	Decedent's Name (First, Middle, Last)	Kobert	K		nan	2. Date of Death Month Februa		05 10 = 20 FM
	Examir	ier	4a. Facility Name (If not institution, give !	VINVSING C	onten	4b. City, Town, o	al + m	ove	4c. County of De	íath A
	Funeral Director		210 07-4301		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Birth	9. E 918	Birthplece (State or Foreign Country) Maryland
	yland now		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	8e-f st	ector	Maryland	Bal	ltimore			, , , , , , , , , , , , , , , , , , ,		1X Yes 2 No
	with th	Funeral Director	10e. Street and Number 3320 Benson Ave.			10f. Zip Code 21 22 9		10g	. Citizen of What USA	Country?
	ems 2	Inera		12. Was Decedent Ever in U. Armed Forces?	.S. 13. V			Specify Yes or No- rto Rican, etc.)		nerican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic avent, the Medical Examinar must be notified at ADES.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	1	☐ Yes 2⊠ No	Specify:		Specify: Wh	
15.	in 72 h	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Deced (Give i	ent's Usual Occup kind of work done OO NOT use retire	pation during most of wo d)	orking 16	b. Kind of Busines	ss/Industry
212	ed with	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Yard				railr	oad
and	ntat Hy ed oth ed oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	,	
ary L	shoulk nd Me mark mark	P	Robert. 19a. Informant's Name/Relationship (Type)	oe, Print)	Kauff 19b. Mailin	man g Address (Street	Eliz and Number or R	abeth ural Route Number, C	0ss	
	and 2 salth a n 27 la		Denise Halstad	niece				Millersvi		
Baltimore,	ages 1 nt of H : If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crem	sition (Name of latory or other place	· 1		c. Location - City of	
ä	artmer vortent injury	- 9	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer se			matory I	The state of the s	- 11:11:1	ltimore	
<u>~</u>	Department of the position of		beld.	tells of			-	Stallings ad Pasaden	runeral a MD 211	Home P.A. 22
	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that cau the death e cause of each line.	n. Do not ente	1 - 1-	ng, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death V—L WV J
Ħ	/Medical Examiner			Due to (or as a consequ		$2 \times i'a$				weeks
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Obsessor in July that initiated events	Due to (or as a consequ		CAIN				rveel.
760,	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
6876	cate by physici the bu	dicai	d							
.O. Box 6	The law requires that the death certificat tte has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of d	Blivery Day Year
α.	that the de ned by the a detached f		9 ☐ Unknown Part II. Other significant conditions con		ulting in the un	deriving cause giv	en in Part I	23a Did tohac	co use contribute	to the cause of death?
Records,	v requires tha been signed should be del	eted by						1 Tes		Probably 4 Junknown
		Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	Physician: r this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA Oth	- /	ath <i>(Check only one)</i> Home 5 ☐ Residence	s ∈ □Other (Se	
Division of	ding Phys h. After this funeral di	Din:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how i		эспу)
isio	ten leat tor: the	icati	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No	206		
Ω	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	i Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	r)			28f. Location (Stree City or Town, S	tate)	
	ne Hos	Medicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Examin	icien: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or inve	occurred at the tine estigation, in my of	ne, date and place pinion, death occi	e, and due to the caus arred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	7 - /	1 1000	29c. License	e number	29d.	Date signed (Mon	th, Day, Year)
				why	1211)	0	5539	1 Fe	bruary	2,2005
	3		30. Name and address of person who con Ming Vi 332 C	npleted cause of death (Item 2	tuer	rint)	Saltin	nove N	anylon	nd 21227
	Sta Registr	te ar	31. Date filed (Modin, Day, Year)	Seriegistrar's Signat	A				i	

ORIGINAL

			For 1_ State			d / Dep	artmen	t of H	ealth	and M	lental Hyg	giene	05	0201.0
			Registrar	f ==4)		Ce	rtificate	e or L	Jeath		2. Date of Dea	leg. No U	UU	0 0 0 4 U
	Physici	an	1. Decedent's Name (First, Middle, I	Last)		1	KORN	-11	1/1/		Month 2. Date of Dea	Day	Year	3. Time of Death
	/Medic		ROBERT					<u> </u>			Jan		005	2 P M
	Examin	er	4a. Facility Name (If not institution, of BALTIMORE Rehabi	give street and number	PANG	/	/!		Location	of Death		4c. County		
	4		Extended	CARE CER	Hers		+	tino		0411		NA		
ж	Funeral			. Sex 7. / 12∑M 2□F	-	last birthday, Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month Pay Jan 21,	Year)	9. Birthi	olace (State or Foreign Pryland
2	Director		538-01-7221		85	TTS.					JdII.ZI,	1920	I'ld	Tyranu
	pur &		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation						1	10d. Inside City Limits
	anyla sho	_												1 ☐ Yes 2 ☑ No
	Ba-f	ctc		Arundel	P	asaden								
	g 2	100	10e. Street and Number	:11 Dood			10f. Zip	122				10g. Citizen of USA	what Cou	ntry?
	itled within 72 hours after death with the Maryland Hygiene. wher then "natural", or Items 23a or 28a-f show wit, the Medical Evanitrat must be incillised at	by Funeral Director	8019 Long H											
	r de	ne Tue	11. Marital Status	12. Was Deceder Armed Force	s?	.S. 13.	Was Deced	lent of His offy Cubar	spanic Or n, Mexica	rigin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Rae Bla	e - Amen ck, White,	can Indian, etc.
36	or it	F	1 Never Married 2 Married	If Yes, Give	□No	WWII	1 ☐ Yes	2 💢 No	Specify.	:		Specil	y: W	hite
21215-0036	iours iral',	q p	3 Widowed 4 Divorced	Year or Date:	s:									
5	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition <i>Juring</i> mos	st of work	ing	16b. Kind of B	usiness/In	dustry
2	Aithin	ldμ	Elementary/Secondary (0-12)	Colfege (1-4d	or 5+)				,			Doio	k Mai	nufactory
7	lygie her t		12	41		Press	0per		10 Math	ada Nom	- /Fires Adidate			nuractory
pu	be fit d otl	Be	17. Father's Name (First, Middle, La Henry	ist)	Kor	nmann			18. Moth	Edna	e (First, Middle,	Maiden Sumai	G G	ishel
yla	S should be filed with and Mental Hygiene. Is marked other the aumatic event, The In	ပ	· ·											
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship			19b. Mail					al Route Numbe ad Pasad			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28e-f show or other traumatic event. The Wadcal Examinatinal Lymphilised at		Joseph Saunders											
ore	of H fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	t □Removal from Sta	20b. l	Place of Disponentery, cre	osition (Nan matory or o	ne of ther place	9)		Date	20c. Location	-	
Ĕ	Part Ind		'4 □Donation 5 □ Other (Spe	ocify)	Me	tro Cr	emato	ry I	nc.ja	2/7/0)5	Baltimo	re M	aryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		21. Signature o Funeral Service	onse	1 4	2	2. Name an	d Addres	s of Facil	ity St	allings	Funera	1 Ho	me P.A.
m	Dep Pend Pend Pend Pend Pend Pend Pend Pend		Bu 2.	DX 1	1	3	3111 M	lount.	ain 1	Road	Pasaden	a MD 21	122	
8	6, 1		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	ed the dea	th. Do not en	ter the mod	e of dying	, such as	cardiac	or respiratory ar	est,		Approximate Interval Between
	Physician		fmmediate Cause (Finat)		navy	Tra	cf	In	Ceci	im				Onset and Death
8	/Medical		disease or condition resulting in death)	a. Due to (or	-			-6						
8	Examiner													
	70	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consec	uence of):							_	
	uted Insit	min	cause. Enter Underlying Cause (Disease or injury	1										
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or a	as a consec	quence of):								
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal												
687	that the death certificate ed by the attending phys detached for use as the			d										
×	ding	/Me	IF FEMALE:	23c. ff yes, outcom	ne of prean	ancv						234 Da	te of deliv	on/
Вох	atten for u	la	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant			□Ectopic pr □ Other (sp						onth	Day Year
0	he di	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr			_ 0 iiio i (op							
Δ.	that t	유	Part II. Other significant condition	s contributing to death	but not res	sulting in the i	underlying c	ause give	n in Part	I.	23e. Did to	bacco use con	tribute to t	he cause of death?
Records,	signed to	b S	Dementia			-	, -	-			1 D Y	es 2 No	3 🗆 Prof	pably 4 Unknown
Ö	w requir been s should	etec	0 1 1	0.										
ec	has the general has the	ldu	Turpusons	Disesse							24a. Was autop	sy	were auto prior to co death?	opsy findings available impletion of cause of
=	hystcian: The la his certificate has I director, page 2	Completed by Physician/Med											1 Yes	2 🗆 No
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of	Physic this c	2	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DC	Othe	4 X N	ursing Ho	me 5 Resid			fy)
	ng P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of li (Month, i	njury Day Year)	28b. Time of Injury		8c. Injury Work	?		28d. Describe h	ow injury occur	red	
Sio	death. ctor: A the fu	atl	2 ☐ Accident investiga				М	101	es 2]No				
Division	r Att	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 288. Place of	fnjury - At h etc. (Speci		reet, factory	, office			28f. Location (S City or Tow		oer or Rur	al Route Number,
	ital or its af ral D													
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		Physicien: To the be xeminer: On the basis										
•	the H in 24 the F iplete	edi	one)	and manner										
	To the within 2 To the comple	2	29b. Signature and title of certifier				290	. License	number			29d. Date signe	d (Month,	Day, Year)
,			1	MO				05	650	8		ya.	n 3	1, 2005
	(X)		30. Name and address of person w				1	VANG	RONG		HAO	BR	GCC	
	O(1, 1)		3900 Loch	Raven	Bo	ulev	and		Ba	ltis	nore,	MO	21	218
1	Sta	ate	31. Date filed (Month, Day, Year)	100	skar's Sign	ature	4	_						
	Regist	rar	FEB 03	2005	Bester	1/2 /	Angel !	D						

		1 - For State Registrar	State of Maryla		artment of H		-	iene g. No. 2005	0304
Physici /Medic Examir	cal	Decedent's Name (First, Middle, L Aa. Facility Name (If not institution, g	Genevieve	C. Ku	cinski	Location of Deat	2. Date of Death Month Jan 27	Day Year 2005 4c. County of Death	3. Time of Death 4: 55 p, M
Funeral Director	lei	6 Tulip Tree 5. Social Security Number 219-20-6945 Usuel Residence of Decedent	Sex 7. Age (In y	rrs. last birthday) 78 Yrs.	Esse If Under 1 Year Months Days			Baltim	
he Maryland 18a-f show	ector	10a. State 10b. County MD Balti 10e. Street and Number		City, Town or Lo	ex				10d. Inside City Limits 1 ☐ Yes 2 No
23a or 2	Funeral Director	6 Tulip Tree	Court		10f. Zip Code 212	21		0g. Citizen of What Coi USA	anuy?
ice, Man y lating Z 12.13-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Ifea 12 is marked other than "natural", or items 23a or 28s-f show other traumatic event. The Medical Examples in all had at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 疑 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 22 No	ispanic Origin? (S in, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify	e, etc.
d within 72 ho piene. r than "natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most of wor f)	rking	6b. Kind of Business/I	ndustry
VICI YICILIO E IZ I	To Be C	17. Father's Name (First, Middle, La. Constantine	Kropkowski	401 44 11		Cather	me (First, Middle, N	ender	
ges 1 and 2 st tof Health and if item 27 is or other traun		19a. Informant's Name/Relationship Mary Conolley 20a. Method of Disposition 1文禄urial 2 □ Cremation 3	/ daughter	103 D. Place of Dispo cemetery, crer	OSunset sition (Name of matory or other place	ValleyD	rive Sy	City or Town, State, Z kesville Oc. Location - City or T	MD 21784
t. Partmen		'4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	cify)	St.Stan	islaus 2. Name and Addres	on of Facility		Baltimore	
Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly ene * use on each line. a	unatoi	300 Ma	ce Ave.	Baltim	ore MD 2	MeofEssex 1221 Approximate Interval Between Onset and Death
be executed ician and purial-transit	icai Examiner	Sequentially list conditions, france, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a soni c. Due to (or as a cons	sequence of):					98 A - 272 MOO 2011
ath certific ittending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Nio 9 □ Unknown	23c. If yes, outcome of pre 1 □Live birth 2 □F 4 □Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
w requires that the debeen signed by the a	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	
	Completed						24a. Was an autopsy perform 1 Yes 2	prior to o death?	topsy findings available ompletion of cause of
the Hospital or Attending Physician: The hors after death. The Funeral Director: After this certificate himpletely filled in by the funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Worl	er: 4 Nursing H	ath (Check only one lome 5 Resider 28d. Describe hor	nce 6 Other (Spec	ify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not determine	be an Place of Injury A		eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
To the Hospitat within 24 hours To the Funeral I completely filled	edicai	(Check only 2 Medical Exone)	Physician: To the best of my aminer: On the basis of examand manner stated.	knowledge, death lination and/or in	vestigation, in my of	pinion, death occu	irred at the time, da	te and place, and due	to the cause(s)
To To com	W	29b. Signature and title of certifier	augh	_	29c. License	o number	29	d. Date signed (Month	Day, Year)
Oi		30. Name and address of person wh	st Toppa	Rd,	Balt	more	140	21286	
Sta Regist		31. Date filed (Month, Day, Year) FEB 0 3	32. Registrar's Si	gnature	and in	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item State of Mary and / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 6,40 AM **Physician** atter James anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Loch Raven Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Bit 2
(Month, Day Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 216-18-9840 79 Director 01 25 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 ia marked other than "natural", or items 23a or 28a-f show other traumatic event. If a Medical Examination is benefited at 1X Yes 2 ☐ No Baltimore MD NA Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. Funeral 3022 Rosalind Ave Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married XXMarried Maryland 21215-0036 1 ☐ Yes 🏖 No Black Specify Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) mentary/Secondary (0-12) 8th grade Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othen any injury or other traumatic event Be Lucinda Garrison Louis E. Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022 Rosalind Ave, Baltimore, Md Hattie R. Keene-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 2/4/05 Owing Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Timel 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage Ind **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Nan Insulin Dependent Depe 23e. Did tobacco use contribute to the cause of death? Insulin Dependent 3 🗋 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed Dertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 🗌 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 1 ☐ Yes 2 ☑ No P 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attanding 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To tha Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number ich I January 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven Boulevard Battimove, T 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 3 2005

ORIGINAL

			For Stete Registrar	State of	f Marylar		artmen rtificat			and M	ental Hy	giene	005	0301.1.
	Physicia	an	Decedent's Name (First, Middle, II Mildred	Last)		•	Lott	0, 5	- Catin		2. Date of Dea	ath Day	Year	3. Time of Death
:	/Medic Examin	al	4a. Facility Name (If not institution, g		n <i>ber)</i>		4b. City.	Town, or	Location o	of Death	Limin.	4c. Co	Dunty of Death Inne Ar	
	Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)			If Under 2		8. Date of Birt	h	9. Birth	aplace (State or Foreign
	Director		219-30-1488 Usual Residence of Decedent	1 M 2 Q F	70	Yrs.	WIOTUIS	Days	riours	Will I.	Jan 3 ^{Day}	1935	Marj	Tand
	show ed at	o.	10a. State 10b. County	Lobana	10c. C	ty, Town or Lo	Burn	io						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h the Marylan r 28a-f show	Director	Maryland Anne 1	Arundel		Gren	10f. Zip	Code				10g. Citize	n of What Cou	
	sath wit		1667 Marley	AVE	Ident Ever in I	18 13	Was Decer		060	nin? /Sne	cify Vac or No.	. 14	USA Race - Amer	ican Indian
920	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23a or 28a-f show he Mcdreal Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Fo	rces? 2 📉 No re		If Yes, spec		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		Black, White	
15-0	d within 72 ho giene. rr then "natur ine Moorcal	leted	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wo DO NOT us	rk done a	luring most	of workir	ng	16b. Kind	of Business/li	ndustry
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Maryland 21215-0036	d tal	To Be	17. Father's Name (First, Middle, La Clement	st) W	Bra	nham				izab:	<i>(First, Middle,</i> eth	Maiden St	_{umame)} Gil	ley
lary	2 should and Men is marke raumatic	-	19a. Informant's Name/Relationship								Route Numbe			_
	s 1 and f Health item 27 other to	1	Sharon Hartman 20a. Method of Disposition	daught	20b.	Place of Dispo	sition (Nar	ne of			en Burn ^{ate}		1D 2106 tion - City or T	
altimore,	m O		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	gity)		en Hav				/4/0	5	Glen	Bunrei	MD
Ball	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service Lic	censule /	1.	22	2. Name ar			36	allings d Pasad			
	45		23a. Pa. 1. Enter the visease, or co shock, or heart fallure. List or	omplic it is that	lused the dea ach line.	th. Do not en		e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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8760,	sate be executed hysician and the burial-transit	dlcal Ex	resulting in death) Last	Due to	or as a conse	quence of):								
9		Medic	IF FEMALE:	d										
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rds, P.	The law requires that the death certific lie has been signed by the atlending p age 2 should be detached for use as	by	Part II. Other significant condition	s contributing to de	eath but not re	sulting in the u	inderlying c	ause give	en in Part I.		A.P	bacco use		the cause of death?
Record	The law recate has bee page 2 sho	Completed									24a. Was autop perfor 1 \(\text{Yes} \)	sy	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of
Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital: A				Othe	ar.		(Check only o	ne)		
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Division of	uttandin death. ctor: Af the fur	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion t be	of Injury - At		M reet factor	1 🗆 \	res 2□t		8f. Location (S	itreet and N	Number or Rui	ral Route Number,
2	ital or A irs after ral Dire led in by	Certii	4 Homicide determin	buildi	ng, etc. (Spec	ify)					City or Tow			
	To the Hospital or Attanding Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		Physician: To the caminer: On the band man										
	To the within To the Comp	Σ	29b. Signature and title of certifier				290	License	number	-	-	10	signed (Month,	, Day, Year)
	10		30. Name and address of person w	no completed caus	e of death (Ite	m 23a) (Type,	Print)	<u>07</u>	57/	-		kmin	7 5/	200
	Sta	to.	31. Date filed (Month, Day, Year)	32. R	eg far's Sign	ature	230	4,0	iles	Bu	nne.	Mi	J. 2/0	61:
	Registr		FEB 0	3 2005	Malur	. K	Good	20						

MELDRAD LUTT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year IM baugh **Physician** 10:04 1 30 2005 /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner dae WAT 51 d If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 9, 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days **★** M 2□ F Gadsden, AL Director 423-32-8702 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 Ia markad othar than "naturel", or items 23a or 28e-f show any injury or other traumatic evant. It is Medical Example. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Edgewater Anne Arundel 1 Types 2 □ No Director 10f. Zip Code 21037 10e. Street and Number 10g. Citizen of What Country? 429 Silver Run Road United States Funeral 12. Was Decedent Ever in U.S. Amed Forces? *C3*Yes 2 □ No 5/1951 If Yes, Give Year or Dates: 5/1953 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 25 Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Plumber | 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cora Ethel Wright Carl Limbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bethesda, MD 20816 5304 Waneta Road Sandra Kebler/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/04/2005 Brentwood, MD Ft. Lincoln Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Rd. Buha /hoor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Joute /Medical to (or as a consequence of): Examiner ter1050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last physician arts the burial-tr Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 DOA Certification: To this After this 28b. Time of 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To tha Funaral I

completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. Deputy 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D000605 mD of person who complater cause of death (Item 23a) (Type, Print) ONCS MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FFB 03 2005 Registrar

				artment of Health and Mental Hygiene 05 03047
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medio		Robertha Lutz	January 25, 2005 7:32 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			Washington Adventist Hospital	Takoma Park Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		257 - 44-5826	Months Days Hours Min. (Month, Day, Year) Country Georgia
	p >		Usual Residence of Decedent	
	aryla shov	-	10a. State 10b. County 10c. City, Town or Lo	issa say ama
	Ba-f	School		ensburg 1⊠Yes 2□No
	or 2	<u>=</u>	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	within 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-f show the Madical Examiner must be notified at	Completed by Funeral Director	5411 Taylor Street	20710 U.S.A.
	er de Itami	nue	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	s aft	γF	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ₺ No Specify: Specify: Black
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5	n 72	jet	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)
7	with iene. ther	шc	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker Private
0	filed Hygi othar	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
<u>a</u>	ld be ental ked o	To Be	Mort Freeman	Catherine Sims
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinating must be multilad at once.	1		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nd 2 lith a 27 is r trau			Taylor Street Bladensburg MD 20710
ē,	f Healtam		20a Method of Disposition 20b. Place of Dispo	sition (Name of
5	age: ent of nt: If I			coln Cemetery 1/31/2005 Brentwood, MD
altimore,	artme ortar Injur		21. Signature of Funeral Service Licensee	2. Name and Address of Facilitrort Lincoln Funeral Home
m	Dep Imp any			3401 Bladensburg Road Brentwood MD 20722
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	
			Immediate Cause (Final	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a	UNIC STUCK
r	Examiner		Due to (if as a conv. quence or):	
		ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
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8760,	icate be executed physician and s the burial-transit	dicai	d	
9		fedi		
ŏ	taw requires that the death certificate been signed by the attending to should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	23d. Date of delivery
e e	deal ne att	sicie	1 Yes 2 Thomas 4 Pregnant at time of death 5	Ectopic pregnancy Content (specify) Month Day Year
J.	at the de by the a tached	hys	9 □Unknown	
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ecords,	taw r as be 2 sh	ple	- Dio heter Hellus	24a. Was an 24b. Were autopsy findings available
r	The tav	Completed	o account	autopsy prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 □ No
VITa V	ician: Th certificate ector, pag	Be	25. Was case referred to medical	26. Place of Death (Check only one)
010	8 v = 0	10	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	04
	ng Pl fter tl	:uc	27. Manner of Death 1 SNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	
0	Attanding r death. actor: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No
DIVISION	iract iract	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	eet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2	ital c	S		
	To the Hospital or Attandii within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	ledicai		occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the tha mplet	Med	and mariner stated.	
	10 Vir. 0	-	29b. Signature and the of certifier	29d. Date signed (Month, Day, Year)
	./			56147 1127105
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, F	
			DR. NASREEN KANGO	7610 CARROLL AVE. TAKOMA PARK Md
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 3 2005	
	ricgion c		I TO A COOL WASHINGTON YOU WASHINGTON	

			1 - For State Registrar		laryland		artmen			nd Mental F	lygiep Reg. R	21115	030	48
	Physici	an	1. Decedent's Name (First, Middle, Last	,						2. Date of Month		ay Ye	3. Time o	of Death
	/Medi	cal	Yuk Chan Li 4a. Fecility Name (If not institution, give							Janua	cy 30	2005	6:00) A M
	Examir	ner	Shady Grove Adve						Location of	Death	4	lc. County of D		
	Funeral		5. Social Security Number 6. Se	x 7. A	SPITAL ge (In yrs. last	birthday)	If Under		If Under 2		Birth	Montg	omery Birtholace (State	or Foreign
	Director		210-47-7002	□M 2120F	77	Yrs.	Months	Days	Hours	Min. (Month, March	15,	1927	Birthplace (State Country) China	or or origin
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						104 1-14 0	
	Maryl f sho	Į.	Maryland Montgo	merv			ithers	shur	œ				10d. Inside C	lity Limits 5 2√2 No
	r 288	Director	10e. Street and Number		1		10f. Zip		6		10g. C	Citizen of What		
	th wit		7711 Ivy Oak Driv	e				20	877			China		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	ent of Hi	spanic Origi	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A	merican Indian,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 If Yes, Give		1	1 ☐ Yes 2		Specify:	donto i noun, oto.,		Specify:	/hite, etc. Asian	
9	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show he Medical Exemples mast be ricitlined at	ed b	15. Decedent's Edu	Year or Dates:		6a Decer	dent's Usua	L Occupa	tion		105			
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21	filed with Hygiene Ather the	Com	0	College (1-401)	5+)	H	omema	ker				Own H	Home	
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Maryland 21215-0036	~ (0 = =		19a. Informant's Name/Relationship (Ty Kwan Shing Liu/So							or Rural Route Num				
d)	of Health of Health litem 27 I		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of		aithersbu Date			or Town, State	
OE .	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Park	.Lawn	Memo:	herplace rial		oruary 7, 200			e, Maryl	and
Baltimore,	permit. Pages : Department of I Important: If Ite any injury or ot once.		21. Signature of Funeral Service Ucorls	010	101420	22	ark .Name and ert A. West 1	Addres Pun	s of Facility	Funeral Hor Evenue, Rocl	_			
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	the death. D	o not ente	er the mode	of dying	, such as ca	rdiac or respiratory	arrest,	-, raryra	Approximat Interval Bet	te
E	Pnysician	8 19	Immediate Cause (Final disease or condition	Respir	atory	Fail:	ire						Onset and	Death
	/Medical Examiner		resulting in death)		a consequenc									
	0.500	ē	Sequentially list conditions, if any, leading to immediate	Sepsis Due to (or as	a consequenc	ce of):								
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8760,	cate be executed physician and the burial-transit	dicai		ı										
Ø X	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Mec	IF FEMALE:	0- 14							-			
Вох	eath certific attending p	Physician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pre					23d. Date of d Month	,	Year
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ğ	w require been sig should b									1	Yes 2	. □ No 3 □	Probably 4 🙀	Jnknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	oonitel.						Death (Check only				
ō	Phys this aldii	<u>۲</u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	ospital: 1 🔀 Inpatie 28a. Date of Inju		Outpatient	3□ DOA	Other	. 4 □ Nursi	ng Home 5 □ Re			pecify)	
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Division of	Attendi r death. actor: A by the fu	Certification:	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home,	farm, stre				28f. Location	(Street at	nd Number or i	Rural Route Numi	ber.
٥	tal or s afte al Dir ed in	Cert	4 🖸 Homicide	building, etc	c. (Specify)					City or To	own, State	θ)		
	t hour		29a. Certifier 1 Certifying Phys	icien: To the best of	of my knowled	ge, death	occurred at	the time	e, date and p	place, and due to the	cause(s) and manner	as stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Medical		and manner sta	ited.	ariczor iriv				occurred at the time				
	S With		29b Signature and title of certifier)		. (29c.	License		1		, /	nth, Day, Year)	
	2	(4	30. Name and address of person who co	Kirkea		V.CT	- 1	100	6168	,	01	130/	2005	
			Robert Kircaldy, M					rive	. Rock	ville. Ma	rv1a	nd 209	350	
	Stat	e	31. Date filed (Month, Day, Year)		ar's Signature		49		, 100	110	тута	114 200	000	
	Registra	ar	FEB 0 3 20	05 Marie	us It	4	and I							

			1- State of Maryland / Department Registrar Certificate	t of Health and Mo			
	O Dissois		Decedent's Name (First, Middle, Last)		2. Date of Death	2005	3 Time of Death
	Physic /Medi		Luther A. Milliner, SR.		Month 2	05	6.55 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death	4	c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	Days Hours Min.	11-6-25		gin Island
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f s	Director	MD Battimore Owings	Mills			1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number	Code	10g. C	itizen of What Cou	ntry?
	death ma 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	ent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ameri	
36	hours after death with the Maryland tural", or items 23s or 28s-f show at Exa. unst must be notified at		1 Never Married 2 Married 1 Yes 2 No	ify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White,	etc.
21215-0036	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usua	/	166	Kind of Business/Ir	HCK adustry
215	within 72 ene. then "ned	Completed		k done during most of working	19		Qi
	filed with Hygiene. other there		17. Father's Name (First, Middle, Last)		Gr	ccery	Store
lanc	ould be f Mental F larked of	To Be	Abroham Millinep	Anone ((First, Middle, Maide	n Sumame)	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If itam 27 is marked other than "natural", or itama 23a or 28a-f show or other traumatic event, If a Medical Example in multired at	-	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address	(Street and Number or Rural		or Town, State, Zij	o Code)
	1 and 2 Health tam 27		Lorraine Milliner (Daughter) 17 Hunters	s Furge Owin		mb :	21117
nor	Pages hent of hent: If its		20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of	her place)	- 0-	_ocation - City or T	own, State
altimore,	구두모근		21. Signature of Funeral Service Licenses 22. Name and	Address of Facility	hoc Green	Thomas V	Senucox
ä	permi Depar Impor any ir		laugh CJ 8728 L	iberty Read	Kandallst	four, my	21/33
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):				1 hour
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	sit ad	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physician and the burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
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	ertifica ling ph e as th	Med	IF FEMALE:				
P.O. Box	that the death certificed by the attending to detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre			23d. Date of deliv Month	ery Day Year
0	t the d by the ached	hysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (spe	City)			
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ord	w requir been si should		hypertusion		1 ☐ Yes 2	2 □ No 3 □ Prol	bably 4 Onknown
Division of Vital Records,	he taw e has t ge 2 s	Completed	hypertusion		24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
tal	an: Ti tificate tor, pa	a	25. Was case referred to medical	26. Place of Death	1 □ Yes 2 🕅		2 No
Ž	hyalci his cer I direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	Othor		6 ☐Other (Special	(y)
o uc	fing P. After t funera	iuo!		lc. Injury at 28 Work?	8d. Describe how inju		
/isic	Attang r death actor: by the	flcat	2 Accident investigation 3 Suicide 6 Could not be determined each miner of the suicide of the su	1 Tyes 2 No	8f. Location (Street a		al Route Number,
ō	talor rs afte al Dira ed in t	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Stat	'e)	
	To the Hospital or Attanding Phyalcian: The law requires that the death certific within 24 hours atter death. within 24 hours atter death. You has Fundaral Director. After this certificate has been signed by the attending promptelety filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1	t the time, date and place, ar in my opinion, death occurred	nd due to the cause(s	s) and manner as s id place, and due to	stated
	vithin 2	Med	and mainer states.	License number	29d. Da	ate signed (Month,	Day, Year)
}	->		RehadosayD	D 20604		2/2/05	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<u> </u>			
	, Sta	e	Rule rol A. Scr3.40; #450; 16755 Fells Rd, L. Runlle, hd 2163; 31. Date filed (Month, Day, Year) 32. Aggistrar's Signature	•			
	Registra		31. Date filed (Month, Day, Year) FFB 0 3 2005 32. gegistrar's Signature				
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:15PM BETTY LILLIAN MOORE 30, JAN. 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 7464 RACE ROAD HANOVER Year II Under 24 Hrs. 8. Date of Birth (Month, Day, 04/03/ 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Days Hours Months 1 □ M 2 🔀 F 74 Yrs 1930 SOUTH CAROLIN Director 215-28-3230 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show the Medical Examinative must be notified at 1 ☐ Yes 2X No MD Director ANNE ARUNDEL HANOVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 7464 RACE ROAD 21076 "naturel", or items 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐ Yes 2 ☐ No Yes. Give X 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. BLACK If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "na eny injury or other treumatic event once. (Specify only highest grade completed) HOSPITAL ADMIN. Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL CLERK BALTO. CITY HOSP. 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ULYSSES G. BIGBY OTELIA WATERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ABRAHAM H. MOORE / HUSBAND 7464 RACE ROAD, DORSEY, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) CEM 02/04/05 CROWNSVILLE, MD CROWNSYLLL And Address of Facility HOWELL FUNERAL HOME 21. Signaty 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD ter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final dised lie or condition resulting in death) Physician Cance 5 ta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ses 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X**No 1 Yes To the Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 ☐ Nursing Home 5 XI) esidence 6 ☐ Other (Specify)
Injury at 28d. Tescribe how injury occurred 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 ho To the Functional (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street 1650011Eans 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State FEB 03 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** February 2005 7:50 a M McLaughlin Rosemary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Edenwald Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 7, 1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 💢 F Yrs. 218-28-4357 New York Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show frer must be notified at 1 ☐ Yes 2 X No Maryland | Baltimore Towson Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S.A. 800 Southerly Road 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. fited within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: the Medical Exer þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Homemaker Own Home th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be till trent of Health and Mental Hy tant: If Item 27 is marked oth jury or other traumatic event Be F. McLaughlin Lillian Baeder ပ္ Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pocomoke City, Maryland 101 WInter Quarters Drive Anne A. Stephens Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. New Cathedral Cemetery 2-4-2005 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign wre on world 5 rvice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 2411 a CONICUSTIVI MARIE /Medical Due to (or as a consequence of): Examiner onn C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at id be detached for 1 □ Yes 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whithown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 10 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 sing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural After 5 Pending after death.
I Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide Hospital 24 hours a Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier) I-IFBUA 10.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 518 CAMP MAMIZ RUMP JOHNI SHAUENS 32. Poistrar's Signature 31. Date filed (Month, Day, Year) 03 2005 Registrar

Sylvia Manangan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00820 State of Maryland / Department of Health and Mental Hygiene MAN For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SYLVIA C. MANANGAN February 01 2005 0750 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Yea 2-26-1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Months 214-43-5986 1 □ M 263cF 69 Director PHILIPPINE Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Medical Exerciper must be notified at MD BALTIMORE ROSEDALE 1 ☐ Yes 2 🛛 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1223 CHESACO AVENUE 21237 PHILIPPINE or Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: PHILIPPIAN lf Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE COUNTY I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 PUBLIC SCHOOL 5+ **TEACHER** marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traitmails. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTONIO CERVANTES NASARIA (TANDOG) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIANO MANANGAN/HUSBAND 1223 CHESACO AVENUE ROSEDALE, MARYLAND 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X3Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM 2-8-2005 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐ Pregnant at time of death the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 No Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Yes Other: ٩ 2 🗌 No 4 Nursing Home 1 Inpatient 2 XER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending Natural 05 0617 Accident investigation within 24 hours after death To the Funeral Director: Location (Street and Number or Rural Route Number City or Town, State) Suicide 6 Could not be determined Place of Injury - At hon building, etc. (Specify) At home, farm, street, factory, office in by t 28 4 Homicide filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month

certifier

person who completed

2005

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ause of death (Item 23a) (Type, Print)

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egistrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore Maryland 21201

29d. Date signed (Month, Day, Year)

February 01, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore, permit. Pages 1 ar	any injury once.		21. Signature of Freneral Service Licensee		2. Name and Addres			ALE FUNERA ALE, MD 2	L HOME 1237
			23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	he death. Do not en	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

ORIGINAL

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	1. Decedent's Name (First, Middle, Las	(1)				2. Date of Dea Month	ith Day	Year	3. Time of Death
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niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	th	4c. C	County of Deatl	n
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<u> -</u>	27. Manner of Death		28b. Time o	of 28c. Injury	y at	dome 5 ☐ Resid			ify) Group Hom
ertification:	1 StNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Worl	k? Yes 2⊡No		. ,		
fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, st	reet, factory, office				Number or Ru	ral Route Number,
erti	4 Homicide determined	building, etc. (Specify)				City or Tow			
0	29a. Certifier 1 XCertifying Ph	ysician: To the best of my know	ledge, deat	th occurred at the tim	ne, date and place	e, and due to the d	ause(s) a	nd manner as	stated.
603		niner: On the basis of examination and manner stated.	on and/or in	vestigation, in my or	pinion, death occ	urred at the time, o	date and p	lace, and due	to the cause(s)
dica	20h Cignature and title of position	u M		29c. License	e number		29d. Date	signed (Month	, Day, Year)
Medical	29b. Signature and title of certifier								
	29b. Signature and title of cartings			D59/	136	l In	70 h	1	2005
	30. Name and address of person who	Completed cause of death //tom	23a) (Tuno	D584	436		Febru	ary 1,	2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	State of Maryland / State of Maryland / State of Maryland / Per State of Maryl	Department of H me G840 2-17 Certificate of I	ealth and I -05 tas Death	Mental Hy	giene Reg. No. O	
	Physicia /Medic		Decedent's Name (First, Middle, Last) Alasdair James McCown			2. Date of De. Month January	ath Day Ye	3 Time of Death 6
	Examin		4a. Facility Name (If not institution, give street and number) 1404 East-West Highway		Location of Death		4c. County of E	George's
103	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last b 2 2 Usual Residence of Decedent	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 6,	y, _{Year)} 9. 1982 Wa	Birthplace (State or Foreign Country) shington, D.C.
4)	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10a. State 10b. County 10c. City, To Maryland Montgomery Bethe					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the or 2	Dire	10e. Street and Number 6307 Valley Road	10f. Zip Code 20817			10g. Citizen of Wha	,
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, Ite Medical Examinating the malified at	by Funeral	11. Marital Status 1 \(\begin{align*} \text{Marital Status} & 12. \text{Was Decedent Ever in U.S.} \\ Armed Forces? \\ 1 \subseteq \text{Yes 2 \textstyle XNo} \\ 1 \text{Yes 2 \text{SNo}} \\ Yes \text{Give} \\ Year or \text{Dates:} \end{align*}	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto	pecify Yes or No o Rican, etc.)		ates vmerican Indian, /hite, etc. White
Maryland 21215-0036	within 72 hou ane. than "natural	Completed b		a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired	during most of wor	king	16b. Kind of Busin	
9	filed y Hygie other t		17. Father's Name (First, Middle, Last)	Clerk	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	.ore
<u>lan</u>	uld be Jental rked c	To Be	Thomas Ashby McCown		Rosema	ту МсТая	gue	
/lar	2 sho and h fs me			b. Mailing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, Sta	
e,	1 and Health em 27 ther ti		20a Method of Disposition 20b. Place	307 Valley Ro		Data	aryland 2	
nor	ages ent of nt: ff it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemet	ery, crematory or other place Souls Cemeter	000	ary 3,		m, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: ff Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee M01353				Pumphrey 7557 Wis	Funeral Home/ consin Avenue
8760,	Physician /Medical Examiner busing and busing the pring-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause). Due to (or as a consequence cause). Due to (or as a consequence cause).	xication e of):	g, such as cardiac	or respiratory at	rest,	Approximate Interval Between Onset and Death
P.O. Box 68	death certiff e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐Ectopic pregnancy 5 ☐ Other (specify) _			23d. Date of Month	delivery Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed				24a. Was autop perfo 1 Yes	an 24b. Wern prior deat 2 \(\text{No} \) No 1	e autopsy findings available to completion of cause of 2? Yes 2 \(\sum \) No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner? Hospital:	Oth		th (Check only o		2277
0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, a	atlon: To	27. Manner of Death 28a. Date of Injury 28b	Time of 28c. Injury Wor	y at k?		dence 6 🔊 Other (3	SCENE unk
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, building, etc. (Specify)			281. Location (3 City or Tov Highway	Street and Number of No. State 1404 I	r Rural Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the tin and/or investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. Licens			29d. Date signed (N	
	h		30. Name and address of person who completed cause of death (Item 23a).C.M.E.		January 3	0, 2005
			MANGANTA B. KOREW	111 Penn Str	reet, Bal	timore,	Maryland	21201
	Sta Regist		31. Date liled (Month, Day, Year) 32. Resistar's Signature FEB 0 3 2005	Soulis				

			1 - For State Registrar	State of Maryland / Dep		dental Hygie	•	0.005
			Decedent's Name (First, Middle, Last)		runouto or boath	2. Date of Death	. No. 2 U U J	3. Time of Death
	Physici		John Louis Neuba	auer, Jr.		January 2	28, 2005	9:06 P M
	/Medi Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	,	4c. County of Death	1 2 2 3 2
			1203 Guildford Ro	oad	Glen Burnie		Anne Arun	nde1
	Funeral		Social Security Number 6. Sex	IM OFF) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	lace (State or Foreign
	Director			M 2□F 70 Yrs.		Month, Day, Y Dec. 8,1	934 MD	
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Many fish	ξ	MD Anne Ar	undel Glen	Burnie			1 ☐ Yes 2 😿 No
	1 the	rec	10e. Street and Number		10f. Zip Code	100	. Citizen of What Coun	itry?
	h with	a D	1203 Guildford Ro	ad	21060		U.S.A.	
	deat deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
98	or it	y Fu	1 Never Married 2 Married	Yes 2□No	1 ☐ Yes 2 ☐ No Specify:	1 100.7	C===if=	
8	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28s-f show ther than Medical Examinar must be notified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:1937-39	-			white
15	"nat	lete	15. Decedent's Edu (Specify onfy highest grade	cation 16a. Dece e completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring 16	b. Kind of Business/Ind	Justry
12	withi ene. than	J L	Elementary/Secondary (0-12)	College (1-4or 5+)	rester		BGE	
9	filed Hyg other	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
lan	fenta fenta rked ric ev	To B	John Louis Neubau	er, Sr.	Elsie	e Mildred	George	
Maryland 21215-0036	and N		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zip	Code)
	and 2 salth n 27 I	1 5	Mrs. Doris Neubaue		Guildford Road,		ie, MD 2106	50
ore	of He	1 .5	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R		ematory or other place)		c. Location · City or To	
Ē	Pag ment ant: I		'4 □Donation 5 □Other (Specify)	Cedar Hi			rooklyn, M	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mentat Hygiene. Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "naturat", or itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service License	10111	22. Name and Address of Facility Si			
_	₹ □ = ≥ ≥		• Huchalle Ca		Second Avenue S.			21061 Approximate
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Conscience to the mode of dying, such as cardiac or respiratory arrest, but to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Interval Between Onset and Death Monflus
P.O. Box 68760,	death certificate e attending phys d for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delive Month	ry Day Year		
	The law requires that the ste has been signed by the bage 2 should be detached.		Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th	e cause of death? ably 4 Dunknown
l Records,		Completed				24a. Was an autopsy performe 1 Yes 2	prior to con	psy findings available inpletion of cause of 2 No
Vital	clan: ertific ector,	Be	25. Was case referred to medical examiner?	Parasitad.		h (Check only one)		
of	this al d	5	Tes 2_PN0	fospital: 1 Inpatient 2 ER/Outpatie			e 6 Other (Specify	9
n C	ding h. After funer	Certification;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
Division	or Attending after death. Director: After in by the fune	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, s		28f. Location (Stree	et and Number or Rura	I Route Number
Div	P is	ertil	4 Homicide determined	building, etc. (Specify)	risot, factory, office	City or Town, S		, iosio rompor,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	properties in my amining death according	rad as sha size a des-	and almost and discussion	44a a a a c c a a / - \
	vithin o th	Me.	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month, L	Day, Year)
	- >- 0) mark	an M.D	D 39505	To	muan	31 2005
	1)		ompleted cause of death (Item 23a) (Type	Hospital M. G	len Be	umie	MD 21061
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 3 20	32. Figistrar's Signature	29c. License number D 39505 Print) HOSpital M. G			

			1 - For Registrar	State of M	aryland / Depa	artment of He		, ,	200	5 02050
			Decedent's Name (First, Middle, La	ist)		timodito or D	Jul.,	2. Date of Deat	h	3. Time of Death
	Physici		Ted	Nowal	<			Month		ear 05 1837 M
	/Medi Examir		4a. Facility Name (If not institution, gir			4b. City, Town, or Lo	ocation of Death		4c. County of	
			University of	marylan	e).	Balti	mare			
	Funeral		5. Social Security Number 6. S	Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year I	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country) Unk
	Director		210 70 3023	1⊠M 2□F	48 Yrs.	Morturs Days	riouis iviiri.	July 14	, 1956	Country) UTIK
	Du ₃		Usual Residence of Decedent 10a. State unk 10b. County	unk	10c. City, Town or Lo	cation				40d Jasida City Limita
	ges 1 and 2 should be tiled within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-1 show or other treumatic event, the Medical Exacting transitie rediffied at	٥	Tou. State direction. County	unk	Too. Only, Town of Ed	Cation			unk	unk ☐ Yes 2 ☐ No
	28a-1	ect	10e. Street and Number		unk	10f. Zip Code		unle	Og. Citizen of Wha	
	with	Funeral Director	Toe. Street and Number			Tot. Zip Code		uirk	USA	
	eath	erai	11. Marital Status unk	12. Was Decedent	Ever in U.S. 13 1	Was Decedent of Hisp	anic Origin? (See	ocify Ves or No-		American Indian,
10	Iter d	Fun	1 Never Married 2 Married	Armed Forces	?	f Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)		White, etc.
936	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	dir	1□Yes 2XINo .	Specify:		Specify:	white
21215-0036	2 ho	Completed	15. Decedent's E	ducation	16a. Dece	ient's Usual Occupation	on	unk	16b. Kind of Busin	ess/Industry
218	thin 7	pie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	life. I	kind of work done dur DO NOT use retired)	ing most of workii	ng ulik		unk
2	od wil	Con	. 1	unk						
nd	2 should be tiled withir and Mental Hygiene. Is marked other than eumatic event, Ite Ms	Be (17. Father's Name (First, Middle, Last)		unk 18	B. Mother's Name	(First, Middle, M	faiden Sumame)	unk
Maryland	should hand Ment	2								
lar	and ls m		19a. Informant's Name/Relationship		19b. Mailir	g Address (Street and				
	and ealth m 27		University of Mar	yland nos				W1	, MD 212	
3altimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	D	ate 2	20c. Location - City	or Town, State
Ë	ment tent: jury		⁴ ☐ Donation 5 ☐ Other (Special Control of the Control of t	y in state	2		į			
3alt	permit. Departr Importe any inju		21. Signature of Funeral Service Lice Anthony	. Pleasant	- 0 S1	. Name and Address of	of Facility	655 W	Rol+imor	o Ctwoot
_	<u> </u>		Cinthony L	Lewson	M Ba	ate Anator Itimore, M				e Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. Do not entine.	er the mode of dying, s	such as cardiac o	r respiratory arre	st,	Approximate Interval Between
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П	LAGITITIE		Sequentially list conditions,	b					1 + *	
	pe sit	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or j.			1	Λ	
	be executed ician and burial-transit	cam	that initiated events resulting in death) Last	C. Due to (et ee	a consequence of);	_	6 Q	1	M	
8760,	be ex	E E		Due to (or as	a consequence or).		AMI	N TOUGH	EXAMINER	
87	The law requires that the death certiticate be executed tie has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	dicai		d		×	ERTIFICATION APPR	OVED BY MEDIA	-	
9 x	ding	/Me	IF FEMALE:	220 If was autooma	of orognoses		ERTIFICATION APP.	,		
Вох	attend tor us	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Lotopic progriaticy	bes 4		23d. Date of Month	f delivery Day Year
o.	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)				,
۵	that the death ed by the atte detached tor	Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the ur	iderlying cause given i	in Part I	23e. Did tob	acco use contribut	te to the cause of death?
Records,	signed b	1 by	-	3	•					Probably 4 Unknown
Ö	w requir been si should	etec								
3e	sicien: The law s certiticale has b irector, page 2 s	mp						24a. Was an autopsy perform	r prior	e autopsy findings available to completion of cause of
a								1 Yes 2	□ No 1□	Yes 2□ No
Vital	ysicien: is certitic director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	6. Place of Death	(Check only one)	
o	> .ºº 0	၉	1 ✓ Yes 2 ☐ No 27. Manner of Death	1 Inpate					nce 6 Other (Specify)
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Division	Attending or death. ector: Atter by the fune	icat	2 Accident investigatio	16 31 6	uny Al homo form et-					0 0
<u>></u>	l or Attendater death Director: in by the	rtif	4 Homicide determined		ury - At home, farm, stre c. (Specify)	eet, ractory, office	2	City or Town,	State)	or Rural Route Number,
_	pitel		29a. Certifier 1 Certifying Pl		of my knowledge death	popured at the time	data and slave.	LIBEA		sathmore, MD
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director: Atter th completely filled in by the funeral	Medical		niner: On the basis of and manner st	of my knowledge, death f examination and/or invaled	estigation, in my opini	on, death occurre	nd due to the call d at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	o the	Me	29b. Signature and title of certifier	and mannor de	atou.	29c. License nu	umber	29	d. Date signed (M	Ionth, Day, Year)
	- \$ - 0			8-1 -		20111	111200	12 2251	.10-	2005
			30. Name and address of person who	completed source of	leath (Itam 22a) (Turn-		76435R	-15028	vun	11 2005
			W	-Holf			2011	v) (22	475	9.1
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	ene st.	LUCTIV	NIE n	11 2125	21
	Registr		FEB 0 3 2005	Below &						
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		1 - For State Registrar	State of M		-	tificate					Reg. No.	2000	030	159
Physic	ian	Decedent's Name (First, Midd								2. Date of De Month	Day		3. Time of De	
/Medi	cal	Kiyoshi Pat 4a. Facility Name (If not institution		-1		4b Ciby	Tour or	Location of	of Death	Januar	-	County of Deat	10:54	A ^
Examir	ner	6303 Friendshi		,			hesda		JI Death					
Funeral		5. Social Security Number		ge (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th	ontgome 9. Birt	hplace (State or F untry)	oreign
Director		506-38-4053	1 <u>M</u> M 2□F	93	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept.	26, 10	1911 Cal	untry) ifornia	
pu *		Usual Residence of Decedent 10a, State 10b, County	,	10c City	y, Town or Lo	cation							10d. Inside City I	Limits
Aaryla f sho	5												1 Tes 2	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Example intent be neithed at	Director	Maryland Mont	gomery	ье	thesda	10f. Zip	Code				10g. Citi:	zen of What Co	untry?	
3a or		6303 Friendsh	in Court				817					ted Stat		
ms 2	by Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.			spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame Black, White	ncan Indian,	
or ite	F	1 ☐ Never Married 2 🛣 Mar	ried 1 □ Yes 2 🔀	No		1 ☐ Yes 2		Specify:		rricari, etc.)		Specify:	ə, etc.	
ural',		3 ☐ Widowed 4 ☐ Divorce	Year or Dates									As	ian	
"nat	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give	ient's Usua kind of wor DO NOT us	il Occupa rk done d se retired:	ation luring mos)	t of worki	ng		nd of Business/	nstitute	
n and Mental Hygiene. 7 Is marked other then "r raumatic event, the Mud	шо	Elementary/Secondary (0-12)	College (1-4or	5+)	-	cho1o						Mental		
other ent, 1	Be C	17. Father's Name (First, Middle			139	CHOIC	БІЗС		er's Name	(First, Middle,			nearen	
ked ic e	To B	Momota Okura						Fuyı	uko E	Emi				
umat	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address	(Street a				er, City or	r Town, State, 2	ip Code)	
27 lg		Lily A. Okura	/Wife		6303	Frie	ndsh	ip Co	ourt,	Bethe	sda,	Maryla	nd 2081	7
item item		20a. Method of Disposition 1 Burial 2 X Cremation	2 CD	a	lace of Dispo	sition (Nam	ne of			ate		cation - City or		
Department of Health a Important: if item 27 Is any injury or other tra gnce.		1 ☐ Burial 2 Ø Cremation 4 ☐ Donation 5 ☐ Other (³ Mor	ntgome: emator	ry ium.	Inc.		2, 20	005	Betl	hesda,	Maryland	
Departn Imports any inju once.		21. Signature of uneral Service	Licensee		, 22	. Name an	d Addres				Pum	phrey F	uneral H onsin Av	ome/
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		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ause t only one cause on each	ed the death line.	n. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	en
ysician		Immediate Cause (Final disease or condition	Gas	tric	Cancer								Onset and Dea 5 Years	
ledical		resulting in death)	Due to (or a										3 10415	
miner		Sequentially list conditions.	b											
÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	uence of):									
sician and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):									
ysician se burial	caiE		333 15 (5) 4	5 th 50115541	20.100 017.									
attending physical for use as the b	adic		d					-						
USB 3	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								2	23d. Date of deli	very	
To E	ciai	in the past 12 months?	1 Live birth 4 Pregnant			Ectopic pro Other (spe						Month	Day Yea	kΓ
detached	hys	9 Unknown	9□ Unknown											
gned r	by Pi	Part II. Other significant condit	ions contributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.	•	23e. Did to	obacco u	se contribute to	the cause of deat	th?
a plnous	edt	Coronary Arte	ery Disease							101	Yes 20	XNo 3□Pro	obabły 4 🗆 Unk	nown
2 shc	Completed									24a. Was		24b. Were au	topsy findings ava	allable
age	E									autor perfo	imied?	death?	ompletion of caus 2 No	se of
irector, page 2 s	BeC	25. Was case referred to medica	al					26. Place	of Death	(Check only o		, 3, 145		
al direc	To B	examiner? 1∑Yes 2 ☐ No	Hospital: 1 Inpai	tient 2	ER/Outpatier	t 3□ DO	A Othe			-		G □Other (Spec	rify)	
neral		27. Manner of Death	28a. Date of In		28b. Time of	_	8c. Injury Work	at	-	28d. Describe I			•	
he funer	atio	E /\ooksarin	igation	,	jui y	М		res 2 □ I	No					
To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 286. Place of I	njury - At ho	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tox	Street and vn, State)	d Number or Ru	ral Route Number	r,
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completely filled in by the funeral director,		29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To the bes I Examiner: On the basis	of examinat	wledge, death	occurred a	at the tim	e, date an	d place, a	and due to the	cause(s)	and manner as	stated.	
nplete	Medicai	one)	and manner s	stated.					occurre					
COU	2	29b. Signature and title of certifi	5 n1m			29c	. License	number			29d. Date	e signed (Month	, Day, Year)	
./		> Ana	KIV			I)OC	53	615	5	0	201	105	
15		30. Name and address of person	who completed cause of	death (Item	23a) (Type,	,	runa		Vatha	n, M.D		7		
1	151	11125 ROCK	lile rine	#20	8 K	och	ville	M	(D	208	52			
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State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Month **Physician** 2005 EBRUARY 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COURS HOSPITAL ALTIMORE
If Under 24 Hrs. 8. Date
Hours Min. (Mon N) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 214-38-886 Months 1 M 2 X Director IRG Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Madical Examinar must be notified at 1 XYes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 0 USA AGLE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2KNo Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RESSER Pages 1 and 2 should be filed nent of Health and Mental Hygisent: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MANUEL HORTON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EAGLE ST. BALTO 0 IRS (HUSBAND WILLIAM M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 02-05-05 LANS DOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility + Brown 21. Signature of Funeral Service Licensee 140 N. FULTON AVE 23 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ence Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Be Completed by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown ģ been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan page 2 this certificate 2⊡No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examine?
1 res 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 1 Inpatient 2 ER/Outpatient funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 5 Pending 1 Natural Injury death. 1 🗌 Yes 2 No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn 2000 BALTMORE GIANO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

FEB 0 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14 Medica NIA ALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
1-27-35 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 ₹ M 2 □ F Yrs. Va. Director 229-40-6107 7ก Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, If w Medical Examinations be notified at Yes 2 No Glen Burnie Anne Arundel Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21060 Apt. 815 Bensench Circle 7900 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or items 28a any injury or other traumatic event, If & Marical Examples ougs. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Varies Truck Driver 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thaniel Minnie Pollard 2 Melford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16126 Greenwood Church, Montpelier, Va. 23192 Sister Alma Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☑ Donation 5 ☐ Other (Specify) Crownsville, Md. 2-4-05 Md. Vet. Cem. 21. Signature Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) chronic obstructive lung disease Physician /Medical Due to (or as a consequence of): **Examiner** Congective hewt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physiclan/Medical Examiner for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. signed by the 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an renalism autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA P 1 ☐ Yes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 🗌 Yes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

M

State

Aerlyn

31. Date filed (Month, Day, Year)

Street BALLimore, MD 2401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn

M.D.

32. Registrar's Signature

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			For State	State of Maryland		artment of Health and		2000	00000
			Registrar	1	Cei	rtificate of Death	2. Date of Deat	eg. No. UU5	03062
	Physicia	an	Decedent's Name (First, Middle, Last)				Moлth Day Year		
	/Medic	al	CARTER Garret 4a. Facility Name (If not institution, give			4b. City, Town, or Location of De	JANUARY	22 2005 4c. County of Dea	12.50 p M
	Examin	er	Frederick Mem		2 1	Frederick	attı	Frederi	
	Funeral		5. Social Security Number 6. Sec			If Under 1 Year If Under 24 H	s. 8. Date of Birth		
	Director		414-18-0698	M 2□F 88	Yrs.	Months Days Hours Mi	June 23	Year) 1916 Nor	thplace (State or Foreign ountry) th Carolina
	pu ,		Usual Residence of Decedent	10c. City, To					
	anyla ethov	70	10a. State 10b. County	,					10d. Inside City Limits 1
	28a-f	Director	Maryland Carroll 10e. Street and Number	Mount	Airy	7 10f. Zip Code		0g. Citizen of What C	Λ.
	with with	2	4101 Old National	Pike		21771	'	USA	ournity :
	ms 23	by Funeral		12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Am	
9	after or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give 1036 +		f Yes, specify Cuban, Mexican, Pu 1 □ Yes 2∯ No <i>Specify:</i>	erto Rican, etc.)	Black, Whi	te, etc.
93	iral',	d by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates: 1936 t	0	TEL TES ZES NO Specily:		Specify: W	hite
<u>7</u>	within 72 hours after death with the Maryland ene. then "natural", or Hems 23a or 28a-f ehow the Madical Examinat must be nutified at	Completed	15. Decedent's Edu (Specify only highest grad	cation 19 completed)	6a. Dece (Give	dent's Usual Occupation <i>kind of work d</i> one during most of w DO NOT use retired)	orking	16b. Kind of Business	/Industry
7	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ster Sergeant		U.S. Air	Force
ი ე	filed Hygi other ent, I	e Cc	17. Father's Name (First, Middle, Last)				ame (First, Middle, M		
au	ld be lental ked c	To Be	Samuel Erwin Piero	:y		Ella	Mae Wilson	1	
Maryland 21215-0036	shou and M e mar umat	-	19a. Informant's Name/Relationship (Ty	pe, Print) 1	9b. Mailir	ng Address (Street and Number or	Rural Route Number	City or Town, State,	Zip Code)
Σ	and 2 alth a 27 h		Cathy Estanich -	Niece		08 Wolf Den Cour	t Monrovia	a, MD 2177	0
Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-1 show any njury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1	20b. Place	of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or	Town, State
Ĕ	Pag ment ant:		`4 □Donation 5 □ Other (Specify)	Seq.	Vall	ey Mem. Gdns 1/	27/05	Jasper,	Tennessee
39	ermit. Nepart nport ny n		21. Signature of Funeral Service Licens	1000) 22	Name and Address of Facility Rogers Funeral	Home		
-	707 # 0	_	Julen L.			400 Laurel Ave.	South Pa		
			23a. Part1. Enter the disease, or compleshook, or heart failure. List only or	ne cause on each line.	o not ent	er the mode of dying, such as card	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final Isease or condition resulting in death)	J	4	5/5			HOYNS
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		Je.	Sequentially list conditions, if any latering to immediate cause. Enter Underlying Cause (Disease or injury the initiated execution)	Due to or as a consequence	ce of):	- proportion in			740-1-10-17
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x 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy					
P.O. Box	atten for us	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year
o.	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	. 0_	2 Gillor (Speciny)			
σ.	s that ned b s deta	by Pt	Part II. Other significant conditions con	-	_	, , ,	23e. Did tob	acco use contribute to	the cause of death?
Records,	quire an sig uld b	ed b	ALZHEM	MS OBM	ent	14	1 □ Ye	s 2 ⊡ √0 3□P	robably 4 Unknown
000	aw re	plet					24a. Was a		utopsy findings available
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ital R	sician: The law certificate has b irector, page 2 s	m							
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			- For - State	State of Maryland / Department of Health an Certificate of Death	71115 1131163
/	ysicia Medic	an al	1. Decedent's Name (First, Middle, Las A. Fedility Name (If not institution, give	PAYSOUR	2. Date of Death Month Day Year Death 4c. County of Death
	amin eral ctor		4304 Grovelow 5. Social Security Number 6. Se	Avenue Baltimore	NA
the Maryland	nutified at	ector	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	10c. City, Town or Location Patting of Location 10f. Zip Code	10d. Inside City Limits 1 ☑ Yes 2 ☐ No 10g. Citizen of What Country?
III.Q. Z. I.Z. I.J. 00000 be filed within 72 hours after death with the Maryland hat Hygiene. do other then "naturel", or Items 23a or 28a-f show	niner must be	Funeral Director	4304 GYOVELONG 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armod Forces? 1 Dives 2 No	in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
within 72 hours and.	ne. hen "naturel", c e Medical Exan	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grade) Elementary (0-12)	Year or Dates: ucation 16a. Decedent's Usual Occupation	of working Specify: BIACK 16b. Kind of Business/Industry Pathloham Steel
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portilization by Market Pages 1 and 2 s Deportment of Health ar Important: If item 27 is			20a. Method of Disposition 1 Burial 2 Cremation 3 Characteristics 4 Donation 5 Other (Specify	Place of Disposition (Name of cemetery, grematory or other place)	Date 20c location City or Town, State
permit. F Dep rtme Importan	any injur once.		21. Signature of Funeral Service Licentification C. J.		wood Randall Storm MD 21133
Physi /Med Exam	lical		Immediate Cause (Final disease or condition resulting in death)	a	Interval Between Onset and Death PLEATURE
6 be executed sician and	the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du to or as consequence of): C. Due to (or as a consequence of): d.	and of menter
The law requires that the death certificate be executed are been signed by the attending physician and	should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √10 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
w requires that been signed by	should be deta	by	Part II. Other significant conditions or	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown
VICAL DEC icien: The law	tor, page 2 sl	e Completed	25. Was case referred to medical	26. Place 0	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No of Death (Check only one)
DIVISION OF VITA o the Hospitel or Attending Physicien: ithin 24 hours after death. o the Funeral Director: After this certified	e funeral director, page 2	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	sing Home 5 Presidence 6 Other (Specify) 28d. Describe how injury occurred
LINISING To the Hospitel or Attend within 24 hours after death	completely filled in by the	i Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ysician: To the best of my knowledge, death occurred at the time, date and	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hos within 24 hr To the Fun	completely	Medicai		niner: On the basis of examination and/or investigation, in my opinion, death and manner stated. 29c. License number	
4 3)		T.Dardon	completed cause of death (Item 23a) (Type Print) 2 4 6 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	#3011 Baltimore MD
R	Sta egistr		31. Date filed (Month, Day, Year) FEB 0 3 20	05 32 Registrar's Signature Apartle	21215

			For State	State of	Maryland		irtment of H			giene Reg. No. (105	03061
			Registrar 1. Decedent's Name (First, Middle,	I ast)			imouto or i		2. Date of De		, 00	3. Time of Death
	Physicia	an	x .	M		10	2 D'aru	1/4-	Month	Day	Year	-06:21AM
	/Medic	al	4a. Facility Name (If not institution,	sing street and sug	(has)	00	4b. City, Town, or		Januar	/	anty of Death	
	Examin	er	11	1 .	i1 /	. ,	4B. City, rown, or	*	C 1/1	40. 000	Tity of Death	
				6. Sex	7. Age In yrs. I	act hirthday)	If Under 1 Year	Mone 24 Hr	S. 8. Date of Birt	h	9 Birth	place (State or Foreign
П.	Funeral		144-44-7283	1 M 2 XF	52	Yrs.	Months Days	Hours Mir		1952	NEW	JERSEY
	Director		Usual Residence of Decedent									
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	dary f sh	ō	NEW JERSEY CUM	BERLAND	МТ	LLVILL	.E					1∭Yes 2□No
	the 28a-	Directo	10e. Street and Number				10f, Zip Code			10g. Citizen	of What Cou	untry?
	with with		8748 FERRY ROAD				08332			U.S.A		
	filed within 72 hours after death with the Maryland Hygione. ther than "neturel; or tems 23a or 28a-f show ent, the Maulical Examinal remail or mollified at	Funeral	11, Marital Status	12. Was Dece	dent Ever in U.	S. 13. \	Was Decedent of H	ispanic Origin? (Specify Yes or No	- 14.1	Race - Amer	
	fter d r Iter	F	1 ☐ Never Married 2X Marrie	Armed For ed 1 ☐ Yes	2 X No		f Yes, specify Cuba		erto Hican, etc.)		Black, White	, etc.
Ř	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	e ates:		1□Yes 2ሺ No	Specify:		Spe	ecify: WH	ITE
2-003	2 ho	Completed	15. Decedent	s Education		16a. Deced	dent's Usual Occup- kind of work done	ation	ngking	16b. Kind o	of Business/li	ndustry
2	7 nin 7	pie	(Specify only highes: Elementary/Secondary (0-12)		-4or 5+)	life.	DO NOT use retired	d)	UNING			
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פ	a file othe vent,	BeC	17. Father's Name (First, Middle, L	_ast)				18. Mother's N	ame (First, Middle,	Maiden Sur	name)	
<u>a</u>	ould be Mental arked o	70 E	JOSEPH RYAN					GRACE	STRATTON			
	de E		19a. Informant's Name/Relationsh			1	ng Address (Street					ip Code)
	and 2 ealth a m 27 is		JOSEPH PAPARON	E (HUSBA	ND)	8748	FERRY RD	., MILL	VILLE, NJ	08332	2	
timore,	of He of He rothe		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Locati	on - City or 1	Town, State
E	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🛣 Cremation 1 ☐ Donation 5 ☐ Other (Sp		SEA	SIDE C	CREMATORY	1/2	27/05	PALERI	NO, NJ	
a	permit. Page Department Importent: If any injury or once.	li	21. Signature of Funeral Service L	icensee	· · · · · · · · · · · · · · · · · · ·	22	. Name and Addre	ss of Facility	AT HOME			
m	Der Imp		Dennie	11 Alline	The -	<u> </u>	OWENSTEI 8 S. NEW	YORK RI	AL HOME D., GALLO	WAY, 1	J 082	05
	4.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that co	aused the death							Approximate Interval Between
			Immediate Cause (Final	01		ancina /	Embole					Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	u	or as a consequ		MISORC	LS			_	21 min
	Examiner			Dee	p Vei	N TI	nRumbos	26				24/125.
	5.0	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dub to	or as a consequ	uence of):	100-					
V	uted ansit	E in	Cause (Disease or injury that initiated events	ESSI	entia	L 7	ONDO	0 C - 0	1515			5URS.
Ċ.	n an ial-tra	Examiner	resulting in death) Last	Due to (or as a conseq	uence of):		7				
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9	ificate g phys as the	edi									1.	
Box	ndin use	N	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnancy	.,		23d.	Date of deli	
ă	d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4□ Pregn	ant at time of d		Other (specify)	,			Month	Day Year
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s, P	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	anine n sig								1 🗆	Yes 215N	o 3□ Pro	obably 4 Unknown
Vital Record	w require been sign should b	Completed							24a. Was			topsy findings available
Re	Physician: The lav r this certificate has ral director, page 2	III.							auto perfo	ormed?	death?	completion of cause of
B	ificat or, pë	Ö	25. Was case referred to medical					26. Place of D	eath (Check only			2 23110
⋽	Physician: this certific ral director,	00	examiner?		Inpatient 2	ER/Outpatie	nt 3 DOA Oth	or.	Home 5 ☐ Resi		Other (Spec	cify)
of	Phy r this	To To	27. Magner of Death	28a. Date	of Injury	28b. Time o	f 28c. Injur	ry at	28d. Describe			
O	ding th. Afte	tlor	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	· ·	th, Day Year)	Injury	M 1 🗍	Yes 2 □No				
S	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could of determine	not be 28e. Place	of Injury - At h	ome, farm, st	reet, factory, office				umber or Ru	ıral Route Number,
Division	l or A after Dire	Certification:	4 Homicide	buildi	ing, etc. (Specif	(y)			City or To	wn, Slate)		
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin	ng Physician: To the	best of my kno	wiedge, deat	h occurred at the til	me, date and pla	ace, and due to the	cause(s) and	d manner as	stated.
	e Ho e Fulletely	edical	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	ation and/or in	ivestigation, in my o	opinion, death of	ccurred at the time,	date and pla	.ce, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		1		29c. Licens	se number		29d. Date s	gned (Month	h, Day, Year)
	- >- 0) Tela	Cean	1		B) E	00613	92	from	en -	25-2005
	/		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)	0.4		1	0	
	h		PETER DI	ANYI	600	N.	WOLFE	E (A.	BALTI	MORE	120	to the cause(s) 1. Day, Year) 25-2005 21287
	St	ate	31. Date filed (Month, Day, Year)	32. F	Register's Signa	ature	1				•	
	Regist		FEB	U 3 2005 1	All Core	J. J.J.	Come					

State of Maryland / Department of Health and Mental Hygien 03065 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jauary 30, 2005 **Physician** Elsie Pettus 12:15 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrsit Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov 15, 19 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Yrs. 232-36-8701 74 Director 1930 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it e Modical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6601 N. Charles Street 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If of Health Gilchrist Center 6601 N. Charles Street Baltimore, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □ Donation 5 \ Other (Specify) in state 21. Signature of Euneral Struce Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 21201

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Baltimore Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12053 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) _ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 mknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 20 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1050102 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 27. Manner of Death 1 [PNatural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Daw BC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID BEKELMAN MO Charles North 6601 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 03 Goods 2005 Registrar

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760,

Vital

				State of Marylar	•	rtment of I rificate of			giene Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Last		Piero			2. Date of Dea Month	ith Day	Year	3. Time of Death 6
	Examin Funeral Director		4a. Facility Name (If not institution, give BUALETT RST 5. Social Security Number 6. Se 219-22-4587	Health Cent		If Under 1 Year Months Days		Location of Death	4c. County	7 mos	ce (State or Foreign
577	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loca	ation				100	l. Inside City Limits
	r 28a-f s	Director	MD Baltimo	ore	Towson	10f. Zip Code			10g. Citizen of V	Vhat Country	1 ☐ Yes 2 X ☐ No
	23a o	al D	1055 W. Joppa Ro	ad		21 204	+			USA	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show emy injury or other treumatic event, the Medical Examinat must be netitied at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married X ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 .	as Decedent of I Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - American k, White, etc	
Maryland 21215-0020	within 72 ho ene. than "naturi he Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give ki	int's Usual Occu ind of work done ONOT use retire	pation during most of wor ad)	king	16b. Kind of Bu		stry
פֿ	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)		HOME	SMOKET	18. Mother's Nar	ne (First, Middle,			\$^*
ylar	ould be Menta marked maric ev	To E	John Oakley				Margar		known		
Mar.	s 1 and 2 sh of Health and ftem 27 is m other treum	9 8	19a Informant's Name/Relationship (T) Robert R. Bair/a	, , ,	19b. Mailing 2 Hop	Address <i>(Str</i> ee okins P)	tand Number or Ru .aza-Merc	ural Route Numbe antile B	r, City or Tayın. 1dg .	itinoi 1timoi 2120	연, MD. 11
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Gremation 3 □ E 4 □ Donation 5 □ Other (Specify)	Comoval from State	Place of Disposi cemetery, crema rraine	atory or other pla		Date 02/03/20	20c. Location - 05 Ba	City or Towr	
Balt	permit. Departr Importe eny inji		21. Signature of Funeral Service Inches	96		Name and Addro	ROAD, To			eral H	lome, Inc.
)	Physician /Medical Examiner	er	23a. Parti. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Deme			ing, such as cardiad	or respiratory an	rest,	ir C	pproximate interval Between inset and Death
, 0	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)								
x 68760,		-	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
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Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death cer ar death. arctor after. actor After this certificate has been signed by the ettendir by the funeral director, page 2 should be deteched for use.	Completed by						24a. Was a perfor		availa	autopsy findings able prior to letion of cause ath?
<u> </u>	The law ate has page 2:	E O						1□ Y	es 2/2 No	101	res 2□ No
Vita Vita	Physicien: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	hor tr	ath <i>(Check only or</i>			
ion of	nding Phys ath. :: After this e funeral di	atlon: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 K Nursing H	ome 5 Resid			
Divis	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, stree	et, factory, office		28f. Location (S City or Tow		er or Rural F	Poute Number,
	To the Hospital or I within 24 hours efter To the Funeral Dire completely filled in the International Completers of the Intern	edical	29a. Certifier (Check only one) ↑ Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death o ation and/or inve	occurred at the tiestigation, in my	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and ma late and place, a	nner as state and due to th	ed. le cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed		
	6		30. Name and eddress of person who co	moleted cause of death /fto:	m 23a) (Type D	D S	0505	9	Janvar	129	2003
	Ψ		AMON J. CHAS	urs mg (0601N	J Cha	eles St	Bultimo,	e Mo	21200	<i>t</i>
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0.3 200	32. Hegistrar's Sign		all s				,	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend tate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARCIA KIDDICK 200 1:00 AM NGELA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSEPH RITCHIE HOS PICE GALTI HORE
If Under 1 Year If Under 24 Hrs. 8. Date
Months Days Hours Min 445 NIA Date of Birth 1962 (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-76-8805 1□M 2区F 42 Director MAR Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 SON STREET USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SERVICE FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be ROVAL KIDDICK 2 YORREL 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 item 27 i SISTER AVE. BALTO, Mb. 21229 MONASTERV HNNETTE other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) KING MEM. PARK 02-05-05 WOODLAWN Name and Address of Facility, Brown TR. FUNERAL HOME 2 140 N. EULTON AVE., BALTO, MD 21217 21. Signature of Funeral Service Licensee 2. A. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final CANCER Physician UNG YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner use as the burial-transit requires that the death certificate be executed Causa (Disease or that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending death. investigation 1 Tyes 2 No 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add ss of person who completed case of death (Item 23a) (Type, Print) 100 31. Date filed (Month, Day, Year) 232. Registrar's Signature State 0 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2311 2005 <u>30</u> /Medical 4c. County of Death NA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAUTIMOR Agnes P6. Sex tealth cave If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**№**M 2□F Months Hours 218-58-8200 Director Usual Residence of Decedent the Maryland 10a. State 10b. County NA 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director MD Himore Item 27 is marked other then "naturel", or items 23a or 28e-f other treumatic svent, the Medical Examinar must be rivitifis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21229 Completed by Funeral Stone 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after of Department of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: 3/ac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 79 Mether's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Moss 2 rad 19a. Informant's Na a/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katheriny 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Deremation 3 Removal from State 3 4 □Donation 5 □ Other (Specify) etro any injury 21. Signatural Fulleral Service Lice 22. Name and Address of roximate 23a. Pad shop The first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, oct. or heart failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final Physician 212-1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tany, leading to in mediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed 1 that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 200 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Natural 2 Accident 5 Pending To the Hospitel or Attendir within 24 hours a ler death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 37, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Esposi 900 Baltimore (aton Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			-	State of Maryland / De	epartment of Healt	h and Mental Hy	giene
		•	1 - State Registrar	_	Pertificate of Dea	46	Reg. No2005 03069
	Physici		1. Decedent's Name (First, Middle, Last) PHILL	P RIDGELE	Y	2. Date of Dea Month	ath Day Year 1:15 A M
	/Medio Examin	er	4a. Fecility Name (If not institution, give st	reet and number) 0 SPI FA	4b. City, Town, or Locat 150 / Himor	ion of Death	4c. County of Death
	Funeral Director		5, Social Security Number 6, Sex 1127	M 2 F 7. Age (In yrs. last birthe	Months Days Hou	ors Min. 8. Date of Birt (Month, Da	9. Birthplace (State or Foreign Country) 7, 1915 Mary land
	ryland thow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1 [Defense 2 □ No
	th the Ma or 28a-f	Funeral Director	10e. Street and Number	Baltin	10f. Zip Code		10g. Citizen of What Country?
	s 23a	erai	815 N. Dukelan	2 Was Decedent Ever in U.S.	3/3/6	c Origin? (Specify Yes or No	USA 14. Race - American Indian,
920	be tiled within 72 hours after deeth with the Maryland ital Hyglene. ed other then "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Mes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Med 1 ☐ Yes 2 ☑ No Specific Transfer of the Specific Transfer of		Black, White, etc. Specify: Black
21215-0036	n 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	completed) (ecedent's Usual Occupation Give kind of work done during ife., DO NOT use retired)	most of working	16b. Kind of Business/Industry
212	filed withi Hygiene. other then	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	aborer		Cup Co.
Maryland	2 should be filed within and Mental Hygiene. is marked other then aumatic event, It a M	Be	17. Father's Name (First, Middle, Last)		unk		
Mar			19a. Informant's Name/Relationship (Type Lisa Smith - Yran	e, Print) 196. P adauanter 25		A 1.1	er, City or Town, State, Zip Code) 21230
ore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 Decremation 3 Re	emoval from State cemetery,	Disposition (Name of crematory or other place)	2-4-05	20c. Location - City or Town, State CatonSville, mb
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	metro	22. Name and Address of F	acility	
Ĭ.	20 E = 0		23a. Para . Ent. the disease, or complic	tron fless Balto mp 2/229 rrest, Approximate Interval Between			
	Physician		shock/or leart failure. List only on Immediate ause (Final disease condition resulting in death)	e cause on each line.	ie Heart	& Faither	Onset and Death
	/Medical Examiner			Due to (or as a consequence of	ary Arti	my Disc	ase
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,092	te be executed ysician and ne burial-transit	I Exa	that initiated events cresulting in death) Last	Due to (or as a consequence of):		
6876	ficate t physical street	edical	d				
Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	Se 25 es		Part II Other significant conditions con	tributing to death but not resulting in	he underlying cause given in F		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ØUnknown
Division of Vital Records,		Completed by	Bilatural He	el Decubit	is ilcir	24a. Was auto	
tal F	sician: The law certificate has b irector, page 2 s	e Col	25. Was case referred to medical	ia	26.1	1 ☐ Yes	20 No 1 Yes 2 No
f Vi	nysicia nis cert I direct	ToB	examiner?	ospital: 1 Mapatient 2 ☐ ER/Out	Other	☐ Nursing Home 5 ☐ Resi	dence 6 □Other (Specify)
ion o	inding Plath.		27. Manner of Death 1 Katural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Til (Month, Day Year) Inj	me of 28c. Injury at Work? M 1 ☐ Yes		how injury occurred
Divis	el or Atte s after de il Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	n, street, factory, office		Street and Number or Rural Route Number, wn, State)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.			cause(s) and manner as stated. date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	145,417	29c. License num	1543	29d. Date signed (Month, Day, Year) 1-31-05
-	Weigh		30. Name and address of person who co	mpleted cause of death (Item 23a) (I	ype, Print)	nort st. By	ACTIMORE, MOZIZZZ
	St Regist	ate	31. Date filed (Month, Day, Year)	2005 32. Registrar's Signature	Cords	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** РМ Meredith Angela Rosoff JANUARY 30. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F <u>July 12, 1970</u> Director 570-35-7209 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Baltimore 1 ☐ Yes 2 X No Towson Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1523 Providence Road 21286 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be need of Heelth and Mental shiftem 27 is marked o Patricia Michael Jenkins Bahner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Greg Rosoff/husband 1523 Providence Road, Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State
1 Donation 5 Other (Specify) Dulaney Valley Mem. Gardens Timonium, MD 21. Signature of Freneral Service Licenses M01122 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 Coster 23a. al.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ADULT RESFIRATORY DISTRESS SYNURUME if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RHEUMATOID ARTHRITIS Completed SEIZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 ₹ No METHICILLIN RESISTANT STAPHLOCOCCUS AUREUS Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XI Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier MID 1-30-05 luthicum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0 3 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Goarle

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 29, 2005 Joyce C. Remissong January 1650 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🔯 F 1927 Director 328**-**20-2795 Illinois Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or Items 23a or 28e-f show the Madical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 14 Bentana Way United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dealer Antiques other freumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, impurtent: If item 27 Is marked other any njury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Connors ၉ Helen Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Grandin Avenue, Rockville, Maryland Janice J. Remissong/Daughter 20850 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20a. Method of Disposition 20c. Location - City or Town, State February 1, 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State orium, Inc. 1,2005 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service like M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Metastatic Carcinoma Months /Medical Due to (or as a consequence of) Examiner Cancer of Pancreas Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Depression Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has to autopsy rmed? 2X No certificate 1 Yes Division of Vital Hospitel or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Other (Specify) $_{1}$ Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 ☐ Yes 2 X No this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t within 24 hours after of To the Funeral Direct completely filled in by 4 \ Homicide 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MD D09470 January 30, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Avenue, Kensington, Maryland Eugene P. Libre, M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 03 2005

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DHMH 17 Rev 1/2001

Registrar

			For State Registrar	riease i		Int in Black Maryland / D	ера	rtmen	nt of H		Mental Hy		กกร		3073
	Physici /Medic		1. Decedent's Name (F Veronica								2. Date of De Month JANUA	Da		ear 005	3. Time of Death
	Examir		4a. Facility Name (If no	t institution, give	street and numbe	r)		4b. City,	Town, or	Location of De	ath	40	. County of		
			MEMORIAL H		. 7	Nan (la una la at hint	to do . d		BERL.	AND If Under 24 H	s. 8. Date of Bir		LLEGA		(0)
	Funeral Director		213-24-544 Usual Residence of De	0	M 2∑F	74 Nge (In yrs. last birti	rrs.	Months		Hours Mi		y, Year,		Country)	e (State or Foreig and
Maryland	28a-f show	tor	10a. State 10	b. County Allegan	у	10c. City, Town								1	Inside City Limits
di th	3a or 28s st be not	Funeral Director	10e. Street and Number 412 Sc	outh Str	eet			10f. Zip		1502		10g. Ci	tizen of Wha	t Country?	?
5-UUS6	yes it are shown to have ment at the best state of the st		11. Marital Status 1 ☐ Never Married 3 🕅 Widowed 4 ☐	2 Married	12. Was Deceder Armed Force 1 Tes 2 If If Yes, Give Year or Date	s? XNo	ĺ	Vas Dece Yes, spe		ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.))-	14. Race Black, V Specify:	White, etc.	
ocoo-cizio	"natural",	Completed by	(Specify o	Decedent's Edu	e completed)		Deced (Give life. D	lent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ation during most of w	orking	16b. K	and of Busin	ess/Indust	try
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Maryland 2	h and Mental Hygiene. 7 ia marked othar than "Iraumatic event, Iraumatic	To Be C	17. Father's Name (First George F		key			-			ame (First, Middle,	, Maider		roug	
ary E	a mer	-	19a. Informant's Name	Relationship (Ty	pe, Print)	19b.	Mailin	g Address	(Street a		Rural Route Numb	er, City	or Town, Sta	te, Zip Co	de)
Ž ;	alth a		George P.	Ratke/s	son		412	Sou	th S	treet Cu	ımberland	l, MI	215	02	22
baltimore,	Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposi 1 ☐ Burial 2 ☐ C 4 🌣 Donation 5 [remation 3 🗆 P	lemoval from Sta	20b. Place of cemeter)	Dispo: y, crem	sition (Na natory or c	me of other plac	6)	Date	20c. L	ocation - Cit	y or Town,	State
Dall	Departm Departm Importa any Inju		21. Signature of Funer.		lade, Di	rector	St	Name ar 1t1m	Andre ore,	ony Boar	rd 655 W.	Ва	ltimor	e St	reet
E	hysician hysician and hysician e parial-transit	Examiner	23a. P.Int. Enter the cash ck, or heart far Immediate Cause (Findisease or condition resulting in death) Sequentially list condition any i caon give immediate. Enter Underlying Cause (Disease or injurtat initiated events resulting in death) Last	illure. List only or all ions, diate ng ry	A CUTE Due to (or a cut) Due to (or a cut) Due to (or a cut)	RESPIRAT as a consequence of AL PNEU as a consequence of	ORY of): MON	FAI		g, 2001, ab au. a.				Int Or	proximate erval Between set and Death DAY
death certificate he executed	ding physe as th	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mo	nths?		ne of pregnancy 2 Fetal death at time of death		Ectopic p					23d. Date o Month	f delivery Day	y Year
. §	d by the	Physi	1 Yes 2 No. 9 Unknown Part II. Other significant		9 Unknown		the com	, da abrica a	,,	an in Bank I	220 Did+	22222	una contribu	to to the e	ause of death?
ords, r.O	been signed should be c	ted by	RUPTURED		_			idenying c		misi caiti.	1 🗆 1				4 □Unknown
	ite has b	Comple									24a. Was autor perfo 1 ☐ Yes	osy irmed?	deat	e autopsy r to comple th? Yes 2	findings available ation of cause of No
/118	certificate rector, pag	Be	25. Was case referred examiner?	_	leanitely.				0.5		eath (Check only o	one)			
OI VILLA	this all di	2	1 ☐ Yes 2X No	1	fospital: 1 [XInpa					4 I lang	Home 5 Resid			Specify)	
VISION	n elle	Certification;	2 Accident	Pending investigation	28a. Date of Ir (Month, I		njury	М		yat k? Yes 2 □ No	28d. Describe				
	i gitt	Certifi	4 Homicide	determined	28e. Place of building,	njury - At home, far etc. <i>(Specify)</i>	m, stre	et, factor	у, опісе		28f. Location (3 City or Tou	wn, State	e)	ıı mural Ro	oute INUMDer,
J letimoch edt	n 24 hou na Funai	edical				st of my knowledge, of examination and stated.									
, o F	within To th comp	Me	29b. Signature and title	of certifier	2) .	Sine,	9	NA	c. License	4865			te signed <i>(N</i> IUARY		
	s Sta	ite	BARRERA, 31. Date filed (Month, I	ROBUSTIA	NO J., M		ME			ENUE, S	UITE 201	, CU	MBERL.	AND,	MD 2150

			For State	State of M		ertificate of L	ealth and Men		2005	00071
			Registrar 1. Decedent's Name (First, Middle, La.	st)				Reg. No. 1	NG. UUJ	3. Time of Death
	Physicia	an	Betty		mith				2605	2019 PM
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or			4c. County of Death	2014
	Examin	61	Johns Hoplans	Bayvieu		Bath	more MO		NA	
	Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min.	Date of Birth Month, Day, Yea	9. Birthp	lace (State or Foreign
в	Director		02 18 7 9 00 20	□ M 202NF	59 Yrs.	World Days	riours ivini.	2/8/19	145	N.C.
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation			1	0d. Inside City Limits
	daryli f sho	ō	MD NA		Bachm	in e				1X Yes 2 No
	the 1	Director	10e. Street and Number		120011112	10f. Zip Code		10g. (Citizen of What Cour	ntry?
	3a or	0	5203 MORAV	IA Road	Apt. C	21206	5		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of His	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	14. Race - Americ Black, White,	
9	or Ite		1 ☐ Never Married 2 ☐ Married	1 Yes 2 X	No		Specify:	11, 010.7	Specify: Bla	
003	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Jisal Evar, il artinust be motified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	1 10 0			1.0		
15	"nat	lete	15. Decedent's E (Specify only highest gra	de completed)	(Giv	edent's Usual Occupa re kind of work done d DO NOT use retired	uring most of working	160.	Kind of Business/In	Justry
12	withi iene. than	mo	Elementary/Secondary (0-12) 8th grade	College (1-4or		f-Employed	Ē	Se	eamstress	
b	illed Hyg other	0	17. Father's Name (First, Middle, Last,		,		18. Mother's Name (Fir	st, Middle, Maid	en Sumame)	
lar	uld be denta rked tic ev	To B	Robert		Blair		Ruby	Мо	cCray	
Maryland 21215-0036	sho and h		19a. Informant's Name/Relationship (Type, Print)			nd Number or Rural Ro	ute Number, City	y or Town, State, Zip	Code)
	and ealth m 27		Lynette M. Blair	Proulx		leteor Dt.,			21234	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exactinating the multiple at once.		20a. Method of Disposition 1	Removal from State	20b. Place of Dis cemetery, cr	ematory or other place	Date Date	20c.	Location - City or To	wn, State
ţ	t. Pa rtmen rtent: njury		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			Iill Cem. 22. Name and Addres	2-7-05		ddle River	
Bal	Deparming Department of the series of the se		21. Signature of Funeral Service Licer	, War	_				ore, Md. North Ave	21202
			23a. Part1. Enter the disease, or com	plications that caused	d the death. Do not e	March F.H.			NOLUI AVE	Approximate
	Pnysician		shock, or heart failure. List only Immediate Cause (Final	6			wille marke	-bucke		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of):	reinoma	with meta	110313		6mmms.
Ü,	Examiner		Conventingly liet conditions	b						
-	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
٧,	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to for as	a consequence of);					
8760,	be ex ician buria				2 00/130q20/100 31/,					
687	tificate ig phys as the	edical		_ d						30 02
Вох	eath certif attending for use a	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	эгу
	death e atte ad for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant a		Ctopic pregnancy Other (specify)			Month	Day Year
P.0	that the deatt ed by the atte detached for	Physici	9 🗆 Unknown							
Ś	S C 90	þ	Part II. Other significent conditions of	contributing to death b	out not resulting in the	underlying cause give	n in Part I.		o use contribute to the	
ord	w requires been sign should be	ted	Traveleng F	1000	100 sence	The Theat	3	1 Tes	2 □ No 3 Prob	ably 4 Unknown
ec	aw Is b	ompleted	anemia, ne	patris	C, hyp	er ensto	<u> </u>	24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
al F	Th ate pag	0						1 ☐ Yes 212		2 No
of Vital Record	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ont 30 DOA Othe	26. Place of Death (Ch			
	Phys r this ral di	1: To	1 Tyes 2 No 27. Manner of Death	1 ☐ Inpati	ury 28b. Time	of 28c. Injury	at 28d.	Describe how in		/)
on	Attending r death. ector: After by the fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	ay Year) Injury	Work	? ′es 2 □ No			
Division	or Attendiater death. Director: A	ifice	3 Suicide 6 Could not be determined	200. Flace Of III	jury - At home, farm, : tc. (Specify)	treet, factory, office	28f. l	Location (Street City or Town, Sta	and Number or Rura	Route Number,
	tel or safte al Dir	Certification;	Tiomode	Duitding, C	to. (Specify)					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical					e, date and place, and dinion, death occurred at			
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner st	ated.	29c. License	number	294 [Date signed (Month,	Day Year)
1	Twie G		The LM.	double		17/1	7/55	200. 0	2/1/00	-71/
•			30. Name and address of person who	completed cause of	death (Item 23a) (Typ	Print)	1103		17-5	
	2				reet	Bact, n	no 212	02		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	Back, n				
	Registr		FEB 03	2005	sever the	Greeke				

TERRY STEVEN STREET 05-00737

	737 0737–ur	ık ,	For State Registrar	State of Maryland		rtment of H			ne N2 0 0 5	03075
	Physici		1. Decedent's Name (First, Middle, Last) Terry	Steven		Street		2. Date of Death	29, 2005	3. Time of Death 1:43a M
	/Medio Examin		4a. Facility Name (If not institution, give si			BALTIMO		1,1,1	4c. County of Death NA	
	Funeral Director		5. Social Security Number 212−98−7872 6. Sex Usuel Residence of Decedent	7. Age (In yrs. la M 2□F 23	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo 8-8-81	ear) 9. Birthp Cour	place (State or Foreign Md.
	a-f ahow	ctor	10a. State 10b. County Md. NA		Town or Lo Baltim				1	10d. Inside City Limits
	ath with the s 23a or 28 ust be no	ral Director	10e. Street and Number 3805 Cedarhurst R			10f. Zip Code 2120			Citizen of What Cour	
980	i 72 hours after death with the Marylan "natural", or Items 23a or 28a-1 ahow olical Examilter mat be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 _Yes 2 \(\overline{A} \) No If Yes, Give \(\overline{A} \) Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	вслу Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	withir ene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9th grade		(Give	ent's Usual Occupa kind of work done o OO NOT use retired	furing most of worki	ing	b. Kind of Business/In Baltimore	
land 2	be filed ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last)	Α	Street		18. Mother's Name Karen	e (First, Middle, Mai		
	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relationship (Type Karen Oakley	Mother	3805		cst Rd.,	Baltimore		206
Baltimore,	Page: nent o ant: If ury or		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service ↓ Signature	moval from State Voi	metery, cren shell	natory or other place	_{e)} den 2–4–	05	Dundalk, Martimore, Mo	ld.
Ba	permit. Departn Importe any inju		23a. Pant1. Enter the disease, or complice shock, or heart failure. List only on	e		March F	.H. East	1101 E.	North Ave	Approximate
	Physician /Medical		snock, or near failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	Sun		sel of	Head		Interval Between Onset and Death
	cate be executed cate be executed by sician and the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
.O. Box 6	The law requires that the death certificate title has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be dek	by	Part II. Other significant conditions con	ributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.		cco use contribute to the	
al Records,		Completed						24a. Was an autopsy performed 1 XYes 2	d? prior to co	psy findings available mpletion of cause of 2 No
Vital	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? XXYes 2 \(\) No	ospital: 1 ☐ Inpatient 2 XX	R/Outpatien	t 3 DOA Othe	30	n (Check only one)	e 6 □Other (Specific	···
ion of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of		at (?	28d. Describe how		7
Division	ire d	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	fourd	in which		Strut, Bel	et and Number or Rura State) 200 Nov	my card
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 A Medical Examin	er: On the best of my know er: On the basis of examinati and manner stated.		estigation, in my op	pinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
)	To cor	~	29b. Signature and title of certifier	King m	N	OCME	,		NUARY ,	2005
	6		30. Name and address of person who complete of the control of the	mpleted cause of death (Item	111 H		ET, BALTI	MORE, MAR	RYLAND 2120)1
	Sta Regist		FEB 0 3 2005	Media St.	Good					

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registral 0.5Certificate of Death Rag. No: Desedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0150 3 2005 JANUARY /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NA timore OS 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 10 M 2/2 F Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at TIMORE 1 es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 5 or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Depurtment of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or iter any injury or other treumatic event, If a Medical Exacitrat once. Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 Tho ASIGN Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bartender tyrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 unk 19a. In walker Smith - Numer Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) dale Nusbana 2/2/3 Balto. 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) IETRO CREMATORY 21. Signature i Funeral Service Lice viee P. March Flit 270 Fredhilton Pass Balto Mo 23a. Pain. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS 2 days /Medical Oue to (or as a consequence of): **Examiner** GIT / PELVIC BLEED Sequentially list conditions, if any, leading to immediate the sequence (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 1 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the i detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 4 🗷 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy Yes To the Hospitel or Attending Phyeicien: within 24 hours after death.

To the Funerel Director; After this certifics 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Tyes 2 **X**No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01,23,05 AT 2438946-E8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

GAUTAM

31. Date filed (Month, Day, Year)

GULATI

03

201

2005

PRWY BALTIMORE MD 21218

EAST UNIVERSITY

32. Registrar's Signature

A Shipping

DHMH 17 Rev 1/2001

Registrar

FEB 0 3 2005

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend item 29d per dyr 8840 2-3-05 vt
State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar				artment of rtificate of				Reg. No.	2000	00	307
ior		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	Day	Year		of Death
iar ica	1	Gary Paul Smaril							January	1			22PM M
ne	r í	4a. Facility Name (If not institution, giv		D # 1- o		4b. City, Town,				4c.	County of Dea	th	
r	4	5109 A4 Baltimore 5. Social Security Number 6. S				If Under 1 Yea	timore	24 Hrs.	8. Date of Bir	th	9. Bir	thplace (Stat	te or Foreign
		213-58-2540	⊠ M 2□F	54	ast birthday) Yrs.	Months Day	s Hours	Min.	07 % TZP1	950	Man	ry Land	
	-	Usual Residence of Decedent		10.00	-							10d Incide	City Limits
١,	. 1	10a. State 10b. County		10c. City	, Town or Lo		_ 1 _ 2						es 2 No
100	ပ္က	Maryland 10e. Street and Number				10f. Zip Code	altimo	re		10g Citi	izen of What Co	ountry?	
è	5	5109 A4 Baltimore	National	Pike			229			-	ed Sta		
0	Funera	11. Marital Status	12. Was Decedent	Ever in U.S		Was Decedent of If Yes, specify Cu		igin? (Spe	cify Yes or No		14. Race - Ame	erican Indian	,
Ü	2	1 Never Married 2 Married	Armed Forces? 1 Yes 2 2 1 If Yes, Give			it Yes, specify Cu 1 ☐ Yes 2 Ž N			rican, etc.)	-	Black, Whit	me, etc. Vhite	
7	o c	3 Widowed 4 Divorced	Year or Dates:								Specily:		
000	Completed by	15. Decedent's E (Specify only highest gra			16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use reti	upation ne during mos	st of working	ng	16b. Ki	ind of Business	/Industry	
2	d.	Elementary/Secondary (0-12)	College (1-4or	5+)		L Servan				U.S.	Gover	nment	
		17. Father's Name (First, Middle, Last)					er's Name	(First, Middle				
	10 Be	John R. Smarik, S	Sr.				Geor	gia N	Merrill	-			
1	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stre	et and Numb	er or Rura	l Route Numb	er, City o	r Town, State,	Zip Code)	
ı		John R. Smarik, S	Jr.(Brothe	r)	8921	Veto Rd	., Bel	pre,	OH 457	14			
		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from State	CG	metery, crei	sition (Name of matory or other p			ate		ocation - City or		
		'4 □ Donation 5 □ Other (Special		Lak	e Viev	v Cemete	ry	02/05	5/2005	Syke	sville	, Mary	1and
		21. Signature uneral Service Lice		M0129	$0 \begin{array}{c} V^2 \\ 16 \end{array}$	Name and Add Ltzke fu 30 Edmo	ress of Facil neral ndson	Home Ave.	of Cat , Cator	onsv	ville, le, MD	Inc. 21228	
	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilated events resulting in death) Last	b. Due to (or as	a consequ	sence of):	Infa	rcho					5 m	rinufe
the state of the state of	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pregnar □ Other (specify)					23d. Date of de Month	Day	Year
1	۵	Part II. Other significant conditions	contributing to death b	out not resu	ilting in the u	inderlying cause	given in Part	1,	23e. Did I		use contribute t	o the cause robably 4	
	ompleted								24a. Was auto perfe		24b. Were a prior to death?	completion	igs available of cause of
(ပိ	25. Was case referred to medical	1				oc Plac	o of Dooth	1 Yes	2 (No	1 PYes	s 2 No	
0	m	examiner?	Hospital: 1 Dippati	ent 2 🗀	ER/Outpatie	nt 3 DOA	Othor		(Check only one		6 ☐Other (Spe	acifu)	
	0 :	27. Manner of Death	28a. Date of Inju	iry	28b. Time o			-	28d. Describe			,0,7	
3	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ty 10al)	Injury	M 1	Yes 2]No					
- 17(V	Certification:	3 Suicide 6 Could not to determined		jury - At ho tc. (Specify	me, farm, st	reet, factory, offic	C O	1	28f. Location (City or To		nd Number or R e)	lural Route N	lumber,
	ledical C		hysician: To the best miner: On the basis of and manner st	of examinat									60(S)
1	0	29b. Signature and title of certifier				29c. Lice	nse number		I	29d. Da	te signed (Mon	th, Day, Yea	r)
100	Σ	. 0 - 0	11 10 -	-						:)	0005
	2.	12 ODE IT I	100-		MI		15/11	26		Je h	1710-	2 ~	2005
100	2	30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	0514	26	esvilla	feb	reary	2 ~0	2005

		For State Registrar		Maryland / Depa	artment rtificate				Re	g. No.2	105	0307
Physicia /Medica Examine	al	Decedent's Name (First, Middle, La. A. Facility Name (If not institution, give	Lora e street and number	•	4b. City, To	wn, or Lo	cation of [Date of Death Month Jan 3	Day 1 2	Year 005 ity ol Death	3. Time of Death
Funeral Director		1813 Old East 5. Social Security Number 235-30-2054 6. S		• Age (In yrs. last birthday) 86 Yrs.	Esse	Year If	Under 24 Hours	Min.	Date of Birth (Month, Day, 11 y 12,	Year)	9. Birth	ce place (State or Foreig TVirgini
ъ	ior	Usual Residence of Decedent 10a. State	ore	10c. City, Town or Lo	ocation ddle	Riv	er		11 y 12 y	1310		10d. Inside City Limit
th with the 23e or 28e.	Funeral Director	10e. Street and Number 14 North Hawt	horne R	oad	101. Zip C	220				g. Citizen o	f What Cou	ntry?
urs a	Ď	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2[If Yes, Give Year or Date	STN0	Was Deceder If Yes, specify 1 ☐ Yes 2∑	No S	Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)	ВІ	ace - Ameri lack, White, inWhit	etc.
ed within 72 h ygiene. her then "natu t, the Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1.2.t.h	de completed) College (1-4d	(Give	dent's Usual (kind of work DO NOT use lachir	done duri retired) 1est	ing most o			6b. Kind of Amer	ican	•
2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the M	To Be	17. Father's Name (First, Middle, Last) ISac E. Mur 19a. Informant's Name/Relationship (phy	10h Maili	a Address /9		Syl	via	Benne Boute Number,	tt		Codal
permit. Pages 1 and 2 s Department of Health an Important: If item 27 is 1 any injury or other trau		Earl R. Smit. 20a. Method of Disposition 1	h / so:	n 552 20b. Place of Dispo cemetery, crea NorthFo	SSAGE sition (Name matory or other or kMem	efie of er place) NOTI Address o	al 2	ive Date /5/0 Conr	Harri 9 2 05 R nellyF	sonbu oc. Location ivert unera	urg V n-City or To ton W alHom	A 22801 own, State IVA neofEsse
ate be nysicia he bur	edicai Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 ry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence of):		of dying, s		rdiac or re	altimo espiratory arre			Approximate Interval Between Onset and Death
at the death certifica by the attending ph tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Milyo 9 ☐ Unknown		n 2 ∏Fetal déath 3[t at time of death 5[Ectopic preg Other (spec					1	ate of delive fonth	ery Day Year
		Part II. Other significant conditions of	ontributing to deat	h but not resulting in the u	nderlying cau	se given i	n Part I.			acco use co		he cause of death? pably 4 Sunknow
The la ate has page 2	Completed									ed?	. Were auto prior to co death? 1 \(\text{Yes}	psy findings availab mpletion of cause of 2 No
ding Phys n. After this funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of I. (Month,		28c	Other: Injury at Work? 1 Yes	4 🗌 Nursi	ng Home 28d	5 Resider Describe how	v injury occu		fre sted
To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	al Certif	4 Homicide determined	building,	Injury - At home, larm, streetc. (Specify) est of my knowledge, deat	n occurred at	the time,	date and p	place, and	City or Town,	State) Jse(s) and n	nanner as s	al Route Number,
To the Hc within 24 To the Fu completely	Medical	29b. Signature and file of certifier 30. Name and address of person who	and manner	ret	29c. L	icense nu		· · · · · · · · · · · · · · · · · · ·	29	d. Date sign	ed (Month,	Day, Year)
Stat Registra		Charles Bo 31. Date liled (Month, Day, Year) F.E.B. 0 3	ult 550			ewC	ircl	e B	altimo	ore M	D 212	224

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M	lental I	Hygiei	200)5	030	080
	Physici	an	1. Decedent's Name (First, Middle, Last,								2. Date of Month			Year	3. Time of	
	/Medio		Josephine M 4a. Fecility Name (If not institution, give		oer)		4b City	Town or	Location of	of Death	Jan.		2005 4c. County o	f Doath	11:05	5 A M
	Exami	lei	College Man		,				hervi					ltim	ore	
	Funeral	-	Social Security Number 6. Security Number	х 7.		last birthday)	If Under Months		If Under		8. Date of	Birth Day Yea			place (State o	or Foreign
	Director		Usual Residence of Decedent	JM 26JF	8	7 Yrs.	Wichins	Days	110013		July	2, 1	917	New	"Ĵerse	<u>.</u> y
	land w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside Ci	ity Limits
	Mary Feb	ţŏ	Md. Harfo	rd			М	onkt	on						1 🗆 Yes	2 K] No
	or 28s	Funeral Director	10e. Street and Number				10f. Zip		<u> </u>			10g.	Citizen of Wi	nat Cour	ntry?	
	ath wi	rai	3611 Lord Baltim					21	111				US	SA		
	tems	une		12. Was Deceded Armed Force	es?	I.S. 13.	Was Deced If Yes, spec	ent of History	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-		- Americ White,	an Indian, etc.	
336	urs att	by	1 ☐ Never Married 2 ☐ Married 3 ĈÓWidowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	∑X No	Specify:				Specify:	WI	hite	
Maryland 21215-0036	filed within 72 hours atter death with the Maryland Hygiene. yther than "natural", or flems 23a or 28a-f show ent, the Medical Examiner must be mufflied at	Completed	15. Decedent's Edu	cation		16a. Deced	dent's Usua	I Occupa	ition			16b.	Kind of Bus			
2	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	kind of wor DO NOT us	e retired)		of worki	ng			thi	_	
2	Hygier Hygier other th	S	0				Seams	tres			come in a late		<u>Manufa</u>		ring	
anc	intai H ed ot	Be c	17. Father's Name (First, Middle, Last) Anthony Simic	ono					Chri			_{dle, Maid} Ріпа	en <i>Sumam</i> e, 11a)		
2	2 should be fand Mental I is marked of aumatic eve	10	19a. Informant's Name/Relationship (Ty			19b. Mailin	na Address	(Street a					y or Town, S	tate Zin	Codel	
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show may injury or other traumatic event, the Medical Experience and be notified at once.		Mr. Thomas A. Sabia	a/Son									Mary1			
altimore,	es 1 a of Hea fitem		20a. Method of Disposition			Place of Dispo	sition (Nam	e of		C	ate		Location - C			
Ĕ	permit. Pages Department of I Important: If its any injury or o	l .	1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entomb Dulaney Valley Mem. Grd.								1/05	Tim	onium.	Mar	rvland	
Balt	permit. Depart Import sny inj once.		21. Signature of Lineral Service Litenspectors 22. Name and Address of Facility Run 1050 York Road To								k Tow	son	Funera	1 Hc	ome, I	nc.
	0.05 * 0	_	220 Part 1 Sator the disease or compli	ling									yland	2120		
E			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	ne cause on eac	n line.			3			1	y arrest,			Approximate Interval Bety Onset and D	ween
	Pnysician /Medical		disease or condition resulting in death)	Due to (or	as a conseq	MYELLO	CYII	<u></u>	LE	UKE	MIA					
	Examiner		Conventially lies and dainer).		30,100 0.7.										
	D H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury		as a conseq	uence of):								2		
9	and and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseq	uanas of):					<u>.</u>					
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687	ificate g phys	edic														
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outco			Totalia						23d. Date	of delive	ry	
B	ed tor	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnan 9☐Unknow	t at time of d		Ectopic pre Other (spe					-	Month	1	Day Y	'ear
о. О	d by the detection	Phy	9 Unknown													
g D	ires tha signed I	þ	Part II. Other significant conditions con	tributing to deat	n but not res	ulting in the ur	iderlying ca	iuse givei	n in Part I.			id tobacce □ Yes			e cause of de ably 4 ⊟U	
Records,	w require been signal	Completed														
He	The law ate has page 2 :	dmo									24a. W	tas an itopsy informed⊋	pric	re autop or to con ath?	ssy findings a apletion of ca	ivailable iuse of
		ပို	25. Was case referred to medical						OF Diago	of Dooth	1 Te	s 201		Yes	2 □ No	
<u>=</u>	ysician: is certitic director,	OB	examiner?	ospital: 1 ☐ Inp	atient 2	ER/Outpatient	t 3□ DO/	Other		.7 /	(Check on		6 Other	(Snacity	1	
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<u>o</u>	ttendir death. ctor: Af / the tu	catic	2 Accident investigation		, ,	,	М		es 2□N	io						
DIVISION	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location City or	n (Street a Town, Sta	and Number te)	or Rural	Route Numb	oer,
_	spitel ours a neral (29a. Certifier 112 Certifying Phys	isien: To the he	et of my kno	wledge death		t the time	data and	l place o			-> -			
	To the Hospitel or Attending Physicien: whith 24 hours after deals. To the Funeral Director: After this certification in the funeral director, completely tilled in by the tuneral director.	edical	(Check only 2 Medical Examin	ner: On the basi	s or examina	tion and/or inv	estigation,	in my opi	nion, death	occurre	nd due to ti	ne cause(ie, date a	s) and mann nd place, and	er as sta d due to	the cause(s)	
	To th withir To th comp	M	29b. Signature and title of certifier				29c.	License	number			29d. D	ate signed (/	Month, E	Day, Year)	
			Duyare Sono	NO MO			7	D10	1619			Jas	nery	31	2005	•
	5		30. Name and address of person who con	mpleted cause of	of death (Item	1 23a) (Type, F E MIN, ture	Print)	. DI/Z	AJIAF	11	THEO	MIF	MA	. 21	092	
	∜ Sta	e	31. Date filed (Month, Day, Year)			ture	71-1	100	, UVL	1	11/0/	nec ,	, 1-10	1	- /0	
	Registra		FFB 0 3 2	2005	anside .	St. I	Souls									

Registrar

31. Date filed (Month, Day, Year)

THEODORE MIKIN

32. Registrar's Signature

2005

30. Name and address of person who completed cause of death (teg 23a) (Type, Print) STREET, BALTIMORE, MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 21 state the Many land 73 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SPRATT Month Day Year **Physician** MICHAEL JANYARY 26 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NANDALIS TOWN SATIMOR NORTHWEST HOIPITAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** North Carolina 216-42-7730 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show treumatic event, the Medical Examiner rount be notified at 1 ¥ Yes 2 □ No Director **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 617 N. Mount Street 21217 USA Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Joe Spratt Velma Spratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 728 Clayton Street Aberdeen, MD 21001 Don Alexander/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department Importent: If any injury or 2006. Mt. Zion Cemetery 02-05-05 Lansdowne, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Albert Wylie per dvr Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYO CAR DIADNEARICTION Immediate Cause (Final ACUITE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 □ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) axaminar? Hospital: 1 Compatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After within 24 hours after death.

To the Funerel Director: Afte completely filled in the 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37333 JANYARY 26, LOGS 30. Name and address of person who completed cause of death (Item 23g) (Type, Print) NHC, SALTO. MO MO

Registrar

State

31. Date filed (Month, Day, Year)

Elver & Sparke

32. Redistrar's Signature

2005

			1 - For State Registrar	te of Maryland	-		of Health a	and M		21	105	03003
	-0		Decedent's Name (First, Middle, Last)				or Boutin		2. Date of Dea	eg. Nó. (th	<u> </u>	3. Time of Death
	Physici		Raymond Edward		Sm	art			Month January	Day 31	Year 2005	6:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Tow	n, or Location o	of Death			ounty of Death	
			The Annapolitan			Anna	polis				ne Arui	ndel
	Funeral		5. Social Security Number 6. Sex 14. M 2[7. Age (In yrs. last		If Under 1 Y	ear If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day June 17	Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	87	Yrs.				June 17	,191	7 NY	
	land		10a. State 10b. County	10c. City, T	own or Lo	cation						10d. Inside City Limits
	Mary -1 sh	to	MD Anne Arunde	1 G1	len B	urnie					Ì	1 ☐ Yes 2√2 No
	r 28a	irec	10e. Street and Number			10f. Zip Cod	de		1	0g. Citize	n of What Cou	intry?
	th with	Funeral Director	7988 Oakwood Road			2106	51				U.S.A.	
	ams a	ner	11. Marital Status 12. Wa	s Decedent Ever in U.S. red Forces?	13. V	Vas Decedent	of Hispanic Ori Cuban, Mexican	gin? (Spe	cify Yes or No-	14	Race - Ameri Black, White	
0	or its	y Fu	1 Never Married 2 Married 1 If Y	Yes 2√7No es. Give X		☐ Yes 2		, , , ,	mount otoly	S	necify:	
Ś	hours tural',	d by	3A Widowed 4 Divorced Yes	r or Dates:	fo Door	lantia Haval O					wn	ite
5	in 72 "nat	Completed	15. Decedent's Education (Specify only highest grade сотр	leted)	(Give	lent's Usual Oo kind of work do DO NOT use re	ccupation one <i>during most</i> e <i>tired)</i>	t of worki	ng	16b. Kind	of Business/Ir	idustry
7	l with iene. r thar	mo d	Elementary/Secondary (0-12) Col	lege (1-4or 5+)			Enginee			Radio	Elect	ronics
2	filed Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden Su	ітате)	
yland	uld be Aenta rked tic av	To B	Barney Smart				Lou	ise	(unknow	n)		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avent. The Modical Evantral must be notified at once.		19a. Informant's Name/Relationship (Type, Prin	n) sister	19b. Mailin	g Address (St	reet and Numbe	r or Rura	l Route Number	City or T	own, State, Zij	o Code)
	and and in 27 m 27 ner tra		Mrs. Muriel Singleton				d Road,					
כבפ	ges 1 of H if iter		20a. Method of Disposition 1 XBurial	20b. Place ceme from State	e of Dispo: etery, cren	sition (Name on natory or other	place)	D	ate	20c. Loca	tion - City or T	own, State
allillor	Pag tmeni tant: jury		* 4 □Donation / 5 □ Other (Specify)			Cemeter			, 2005			
a O	permit Depar Impor any in		21. Signatury of time at Service Licentee		22	. Name and A	ddress of Facilit	y Sin	gleton	Funer	al Hom	e P.A.
	40 = 0 4		25a. Part 1. Enter the disease, or complications	that caused the death.			l Avenue				11e, MD	Z1U01 Approximate
	S		shock, or heart failure. List only one caus	e on each line.	1 -	or the mode of	dying, socii as	cardiac	i respiratory arr	, jos.,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ue to (or as a consequen	· fee	•					^	nay years
	Examiner			17-18-1	enaci	3Y)					1	non her.
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a consequen	ce of):	- /						
	cuted nd ransit	Examine	that initiated events									
Ç	a exectan ar	EX	resulting in death) Last	ue to (or as a consequent	ce of):							
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Ď	w requires that the death certifics been signed by the attending pt should be detached for use as t	Med	IF FEMALE:									
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5	he de	ysic		Pregnant at time of death Unknown	1 5	Other (specif)	y)					
ŗ	that the ded by detail		Part II. Other significant conditions contributing	g to death but not resultin	g in the ur	nderlying cause	e given in Part I.		23e. Did to	acco use	contribute to t	he cause of death?
cords,	quires n sigr	d by							1 □ Y	s 2 🗆 l	No 3 □ Prof	pably 4 Minknown
3	s bee	iete							24a. Was a		24b. Were auto	opsy findings available
ב	sician: The law certificate has b irector, page 2 s	Completed		· · ·					autops perform	ned?	prior to co death? 1 \(\sum \text{Yes}	mpletion of cause of 2□ No
7 1 2		Ø	25. Was case referred to medical				26. Place	of Death	(Check only on		10103	
	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 💢 No Hospital	1 ☐ Inpatient 2 ☐ ER/	Outpatien	t 3□ DOA	Other: 4 Nu	rsing Hon	ne 5 🗆 Reside	nce 6 🛚	Ōther (Speci	Assisted WLiving
5	ding Ph h. After th funeral		27. Manner of Death 28a. 1 ⊠Natural 5 □ Pending	Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. l	Injury at Work?	2	8d. Describe ho	w injury o	ccurred	
VISION	tendi eath. or: A the fu	cati	2 Accident investigation				1 ☐ Yes 2 ☐ !					
<u> </u>	or Att	ertification;	4 Homicide determined 28e.	Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, off	fice	2	8f. Location (St City or Town		lumber or Run	al Route Number,
	pital ours a erai [0	29a. Certifier 1 ✓ Certifying Physician:	To the best of my knowler	doe doath	occurred at th	no time, date an	d place a	nd due to the o		d mannor as s	tated
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Medical Examiner: On									
	ro the	Me	29b. Signature and title of certifier			29c. Lic	cense number		2	9d. Date s	igned (Month,	Day, Year)
	/) 000 P			T	7405	17		1-	31 - 9	55
	'n		30. Name and address of person who complete	d cause of death (Item 23	ва) (Туре, і	Print)					-1	
			MIRZA NUSAIREC	/	160	67 Ru	ME 3 1	V0.25H	(200	TON,	MD	
	Sta		31. Date filed (Month, Day, Year) FEB 0 3 2005	32. Registrar's Signature	M.	Ingel. 8						
	Registr	aı	LED A 6 7000	Jacquesta A	10							

12121
Maryland
Baltimore,

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Division of Vital Records, P.O. Box 68760,

	1	For State Registrar		State of M	aryland		rtment of F tificate of	lealth and N <i>Death</i>	•	giene Reg. No.		
sician		1. Decedent's Nam	ne (First, Middle, Las	st)					2. Date of De	ath Day U	roar 3.	Time of Death
edical	L			Smith, J					Januar	29 20	205 5	2305
miner	ľ	North A	A ()	e street and number))		A. C	r Location of Death		4c. County	of Death Arunc	101
ral		5. Social Security		HUSPITAL ex 7. As	ge (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		(State or Fore
tor		220-09-3	3024	M 2□F	84	Yrs.	Months Days	Hours Min.	Jan 6,	1921	MD Country)	,
	-	Usual Residence o 10a. State	of Decedent 10b. County	·	10c. City, 7	own or Loc	eation				10d Ir	nside City Limi
Ď		MD	Anne Ar	undel		len B						☐Yes 2∏
Director		10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen of W	/hat Country?	
		905 Ros	edale Ave	nue			210	61		U.	S.A.	
Funeral		11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces?	?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		- American In k, White, etc.	dian,
Ş		3 Widowed		1 √7 Yes 2 ☐ If Yes, Give Year or Dates:	1943-	43 1	☐ Yes 2 No	Specify:		Specify:	white	e
ted		(Sne	15. Decedent's Ed	lucation	1	6a. Deced	ent's Usual Occup	ation during most of work	ina	16b. Kind of Bu	siness/Industry	,
Completed by	-	Elementary/Seco		Coilege (1-4or		life. D	O NOT use retired	d)				
ဒိ		12 17. Father's Name	(First, Middle, Last)	<u></u>		Packa	ging Eng	ineer 18. Mother's Name		Airline		cturin
To Be			rederick						nce Coo		=/	
-			lame/Relationship (7			19b. Mailing	Address (Street	and Number or Run			State, Zip Code	e)
	_	Mrs. Ros	se Smith /	wife		905	Rosedale	Avenue,	Glen Bu	rnie, MD	21061	
	1	20a. Method of Dis 1) Burial 2	sposition Cremation 3	Removal from State	20b. Plac	e of Dispos etery, crem	ition (Name of atory or other plac	(6)	Date	20c. Location - (City or Town, S	State
page. To Be Completed by Funeral Director	-		5 Other (Specify		Glen			ark Feb 3		Glen Bu		
Suc		21. Signature of Pi	uneral Service Licen	Mmail	MO1415			ss of Facility Sin Avenue S.				
er Examiner		Immediate Cause disease or condition to the control of the cause of that initiated cause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, impediate erlying r injury s	b. Due to (or as	a consequen	ea ut);	L Mas	tage				
y Physician/Medical Exa		IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ∫ 9 ☐ Unknown	2 months?	d	2 Fetal de t time of death	ath 3 🗆 8 n 5 🗆	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	Year
Ď	۱'	Part II. Other signi	ficant conditions of	ontributing to death b	out not resultin	g in the und	derlying cause giv	en in Part I.	23e. Did to	obacco use contri es 2 □ No	bute to the cau	se of death?
Comp		25. Was case refer	rred to medical					26. Place of Death		rmed? de 2 No 1 l	ere autopsy fir ior to completi eath? Yes 2011	on of cause o
To Be		examiner?	(No	Hospital: 1 Appatie	ent 2□ER/	Outpatient	3□ DOA Oth	ar.		lence 6 Other	(Specify)	
	2	27. Manner of Deat 1 Natural 2 □ Accident	5 Pending investigation		y Year) 28	b. Time of Injury	28c. Injun Worl M 1 🔲	y at ⟨? Yes 2 □ No	28d. Describe h	ow injury occurre	d	
Certification;		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	building, et	c. (Specify)				City or Tow			te Number,
		29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	ysician: To the best liner: On the basis of and manner sta	t examination	dge, death and/or inve	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurr	ed at the time, o	ause(s) and man date and place, ar	ner as stated. nd due to the c	
Medical	_	29b. Signature and	1 AIA1 6 AI61				29c. License			29d. Date signed	12.66 11 12 1	

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** January 27. 2005 R. 5:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Independence Court of Hyattsville Prince Georges Hyattsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗓 F 579-18-2624 95 Jan 27. Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 No Directo Prince Georges Hvattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 death v 5821 Queenschape1 Road U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: African ≥ 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. 12 Key Punch Operator Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, mit. Pages 1 and 2 should be fill partment of Health and Mental Hyportent: If Item 27 Is marked otty y Injury or other traumatic even Be John Brown Cora Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Fennell- Daughter 2425 33rd Street SE Washington DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. Fort Lincoln Cemetery 2/3/05 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Concestive Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Arteriosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day detached for 4 Pregnant at time of death 5 Other (specify) 2 🗆 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Pe Emphysema 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Hypertension has page 2 : autopsy performed? 2**1** No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) \triangle SST Livin1 ☐ Yes 2 X No 3 DOA Medical Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 1 ANatural 5 Pending after death.

Director: Af
in by the ful 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum Street, NE #021 Washington DC 20017 Kathy Brenneman, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Rachel Ann Sandy January 29, 2005 2:15 p. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Genesis Center Dundalk Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Jan. 22, 1 Birthplace (State or Foreign Country) Months 1 ☐ M 2 ☑ F Director Yrs 29 1976 214-11-1028 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location Item 27 is marked other than "neturel", or frems 23e or 28e-f show other treumatic event. The Medical Eraminer must be required at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 years Dependant N/A Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 James Thomas Sandy Linda Sue Podruchny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sue Sandy (Mother) 833 Loalan Avenue Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ö Department of Importent: If any injury or once. Hilltop Service Corp. 2/2/2005 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) P.O. 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Donknown Completed 1 ☐ Yes 2 ☐ No been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Beath (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 0 1 ☐ Yes 2 ☑ No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Jules MI) person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** William Smith 10:10 A^M January 27, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Eastpoint Baltimore Eastpoint Nursing & Rehab. Ctr. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F Months Days Hours Yrs. 229-24-1000 78 Director April 22,1926 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 3423 Logan View Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Items 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ð White 3 Widowed 4 Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Assembly Line Leader Food Processing Plant 8 Years permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, importent: If item 27 is merked othe any injury or other transmit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rena B. Parker Percy E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3423 Logan View Drive Dundalk, Maryland Mr. Gerald E. Smith / Brother 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Gardens of Faith Cem! 1/31/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Lorald R. Watson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine transit. The law requires that the death certificate be executed and burialattending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4 ☐ Pregnant at time of death the detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 1 Yes 2 No Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4☐ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person State FEB 0 3 2005 Registrar

			For State Registrar	State of Maryland / Dep		Mental Hygi	ene 2005	03000
			Hegistrar Decedent's Name (First, Middle, Last)		Tillicate of Death	2. Date of Death	g. No. UU	3. Time of Death
	Physici	an				Month	Day Year	
	/Media		Armagan A. Sanve				30, 2005	6:00 A M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deatl	1	4c. County of Death	1
			Holy Cross Hosp		Silver Spring		Montgomer	7
	Funeral		5. Social Security Number 6. Sex	M OFF	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, December 5	Year) 9. Birth	place (State or Foreign intry)
	Director		242-64-8003	69 Yrs.		December 5,	, 1935 T_1	ırkey
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	agation			40d Jasida City Limite
	shon	_	Too. County	Toc. City, Town of E	Cocation			10d. Inside City Limits
	Ba-f	cto	Maryland Montgom	ery	Potomac			1 ☐ Yes 2½ No
	ि से 0r 2	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	intry?
	th w		11613 Greenlane Dr	ive	20854	U	nited Stat	es
	dea dea	Funeral	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Amer Black, White	ican Indian,
9	or It	F	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🔯 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:			, 610.
8	ours	by	3 Widowed 4 Divorced	Year or Dates:	1 163 2 2 140 Specify.		Specify: Wh	ite
5-0	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or items 23a or 28s-1 show of other than "natural" or items 73a or 28s-1 show event, I're Medical Examination in the death.	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Dec	edent's Usual Occupation	ting 1	6b. Kind of Business/I	ndustry
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21	d with giene or thau	no:			il Engineer		Construct	ion
힏	Hygie other	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, M.	aiden Surname)	
au		To B	Omer Sanver		Nezaha	at Aral		
2	d 2 should be the and Mental if and Mental if 7 is marked o	-	19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. Mai	ling Address (Street and Number or Ru		City or Town. State. Z	in Code)
Maryland 21215-0036	es 1 and 2 s of Health an I frem 27 ls r other trau							,
o,	1 an Heal em		Ayda Sanver/ Daug	20b. Place of Disc	O Rosalinda Drive	Date	Mary Land Oc. Location - City or 1	
Baltimore,	Pages nent of int: If its iry or o		1 ☐ Burial 2 ② Cremation 3 ☐ R	cometant or	ematory or other place) Febr	uary 3		
틒	tmer tant		' 4 ☐ Donation 5 ☐ Other (Specify)	Cramata	rium Tno 400-		Bethesda,	Maryland
aii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral 5	R R	22. Name and Address of Facility Rol ockville, Inc. 30 ockville, Marylan	ert A. Pi	umphrey Fur ntoomery A	neral Home/
Ш	20 E 2 3		Den	M01405 R	ockville, Marylan	d 20850 T	negomery n	vende
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	/Medical		disease or condition resulting in death)	Asphyxiat Due to (or as a consequence of):	lon			
п	Examiner				n of Emesis			
		5	Sequentially list conditions,	Due to (or as a consequence of):	n or emesis			
1	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury		• . •			
	te be executed ystclan and e burial-transit	xan	that initiated events cresulting in death) Last	Gastroent Due to (or as a consequence of):	eritis			
760,	e be ex			200 to (0, 00 0 00.00400.000 0.).				
87(# × #	licai	d					
.89	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:					10
Вох	th ce endi	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of deliv	•
	deal e att	Cic	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month	Day Year
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۳,	de de		Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	ufres sign ld be	Completed by	Type 2 Diabetes M	ellitus, Hypertens	ion	1 ☐ Yes	a 2⊠No 3∏Pro	bably 4 Unknown
Ö	w require been si should b	ete	Hyperlipidemia			24a. Was an	24h W	
36	The lav	mp	- Hyperlipidemia			autopsy perform	prior to c	opsy findings available ompletion of cause of
=		CO	Gout				Z No 1 ☐ Yes	2 ₩ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			th (Check only one)	
of \	Physic this or al dire	2	1 ☑ Yes 2 ☐ No	ospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	ent 3□ DOA Other: 4□ Nursing H	ome 5 Residen	ice 6 Other (Spec	ify)
	ig Pl		27. Manner of Death	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how	v injury occurred	
Division	Attending In death.	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 22), (22)	M 1 ☐ Yes 2 ☐ No			
Vis	or Attend after death Director: /	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s	street, factory, office		et and Number or Rui	al Route Number,
Ö	afte Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)	
	spits ours nera fille		29a. Certifier 1⊠ Certifying Phys	ician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the cau	use(s) and manner as	stated
	Ho: Fur etely	edical	(Check only 2 Medical Examination)	ner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month	, Day, Year)
1	£. ₹. ₹.		> Rabert H.	lever MD				
7	,0)	* Vialuent 11-		D00055522	Ja	inuary 30,	2005
	/		30. Name and address of person who co		·			
				M.D. 1500 Forest G	len Road, Silver	Spring, M	aryland 20	910
	Sta		31. Date filed (Month, Day, Year)	3 Agistrar's Signature				
	Regist	rar	FEB 0 3 2005	Blance It Co	ach)			

			For State of Marylar	nd / Department of He Certificate of D		ntal Hygiei	4000	03089
		4	Decedent's Name (First, Middle, Last)		2.	Date of Death	Day Year	3. Time of Death
	Physici /Medio		Antonio Thornton)anvary	300 200	5 4:40pm
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	Location of Death	9	4c. County of Death	ו
			0	ledicel Ctr Ba	Itimere	_	NA	
	Funeral		5. Social Security Number 6. Sex	. last birthday) If Under 1 Year Months Days	Hours Min. 8.	Date of Birth (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent			7–11–61		Md.
	yland yland		10a. State 10b. County 10c. Ci	ty, Town or Location				10d. Inside City Limits
	Mar infe	tor	Md. NA	Baltimore				1 X Yes 2 No
	th the or 28	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	untry?
	23a	raic	3418 E. Baltimore Street	21224	4		USA	
9	be filed within 72 hours atter death with the Maryland Ital Hygiene. sd other than "natural", or liems 23a or 28a-1 show event, the Medical Examinar must be positived at	/ Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 ☐ Never Married 2 ☐ Married 17. Was Decedent Ever in U Armed Forces? 1 ☐ Yes, Give	If Yes, specify Cuban	panic Origin? (Specif , Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: F	
21215-0036	ural',	d by	3 Widowed 4 Divorced Year or Dates:					
<u>7</u>	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)		16b	. Kind of Business/I	ndustry
12	withir ene. then	dm	Elementary/Secondary (0-12) College (1-4or 5+)	Disabled			NA	
η Ο	e filed within al Hygiene. I other than " vent, the Me		11th grade 17. Father's Name (First, Middle, Last)		18. Mother's Name (F	First, Middle, Maid		
Maryland	2 should be and Mental le marked o aumatic eve	To Be	Gaither Thornto		Agnes		Cater	
Mar	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and				
	s 1 and 2 of Health a Item 27 le other trai		Shedena Thornton Sister 20a. Method of Disposition 20b. F	3418 E. Bal	ltimore St		More, Ma. Location - City or 1	
و	ages in total		1 ∑Burial 2 □ Cremation 3 □ Removal from State	cemetery, crematory or other place))			
Baltimore,	it. Pr intme intant njury		* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	It. Zion Cem. 22. Name and Address	2-5-0		ansdowne,	
Ba	permil. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		VI-n- / Lun	March F.F		altimore 1101 E.	North Av	.202 .e.
		-	23a. Part 1. Enter the disease, or complications that caused the deal			espiratory arrest,		Approximate
	Pnysician		Immediate Cause (Final	1	= 1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consec	auen@of);	Tallure			5 yes
	Examiner							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
V	cuted nd ransi	Examiner	that initiated events					
Ö,	e exe ian a urial-l		resulting in death) Last Due to (or as a consec	quence of):				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical	d					
9	ertific ding p		IF FEMALE:					
Box	eath certif attending for use a	lan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregn. 1 Live birth 2 Fednant at time of c	al death 3 Ectopic pregnancy			23d. Date of delin	very Day Year
	the de	ysic	1 Yes 2 No 9 Unknown	death 5 🗆 Other (specify)				
P.0	requires that the d een signed by the hould be detached	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause giver	n in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
sp.	uires sign ld be	d b	Henditis C. History	Kehol Abuse		1 🗆 Yes	2 □ No 3 □ Pro	babiy 4 X Unknown
00	> 0 10	lete	, 0			24a. Was an	24b. Were aut	opsy findings available
\mathbb{R}^{6}	9 4 9	duc				autopsy performed	prior to c death?	ompletion of cause of
Vital Records,	viclan: Th certificate rector, pag	0	25. Was case referred to medical	,	26. Place of Death (C	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 X No
		0 8	examiner? 1 ☐ Yes 2 ₹ No Hospital: 1 ★ Inpatient 2 ☐	ER/Outpatient 3 DOA Other	Andrew Control of the		6 □Other (Spec	itv)
10	ig Phye ter this neral di	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury a Work?	at 28d	. Describe how in		,
joi	Attending I r death. ector: Atter by the funer	atic	2 Accident investigation		es 2 No			
Division of	if or Attending I atter death. Director: Atter I in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Special Could not be determined 28e. Place of Injury - At h building, etc. (Special Could not be determined 28e. Place of Injury - At h	nome, farm, street, factory, office	28f	Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	iltal o irs att ral Di lled ir							
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edical	29a. Certifier	owledge, death occurred at the time ation and/or investigation, in my opin	e, date and place, and nion, death occurred	I due to the cause at the time, date :	(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License i	number	29d.	Date signed (Month	. Day, Year)
			MI) RES-	-000	Jan	nvare 3	30,2005
			30. Name and address of person who completed cause of death (Iter	m 23a) (Type, Print)		- 11	7	80, 2005 MD 21224
	10		Bredley Watkins 4940	Eastern	Ave	Bultin	more,	MD 21224
	Sta		31. Date filed (Modifi, Day, Year) FEB 0 3 2005	ature .				
	Registr	ar	I LU V O LUUJ BAR A	A DESTRUCTION OF THE PARTY OF T				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2.3pt2 per doctor 9840 2-3-05 vt.

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. - U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year TAYLOR **Physician** 5:40 AM FLEANOR TANUARY 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUPKINS N/A BALTIMORE CARE CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 ☐ M 2 🖵 F Yrs. Director 81 217-18-0573 Feb. 6,1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it e Medical Evantical must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No by Funeral Director Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 513 Fairview Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restuarant Waitress 5 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elise Dacre Felix Licefi 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 North Point Road Baltimore, Maryland 21224 Mrs. Tina Tallagsen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages : Department of P Important: If ite any injury or ot once. tX Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/2005 Baltimore, Maryland Oak Lawn Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 21. Signatu of uneral Service Licen 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. aus Varion 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STROKE WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NTHS ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine be executed use as the burial-transit CARDIOMVORATH that initiated events resulting in death) Last Due to (or as a cons - uence of): Box 68760. attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Pneumonia ASPIV 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No ပ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO4387 Jan 4024, 24, 2005 -14 By view 505 Hopking 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greeneu 0 o him .13 ins 15att mare 31. Date filed (Month, Day, Year) State JAN 2 7 2005 Registrar

			For State Registrar	State of Ma	aryland / De		of Health and	Mental Hygie	•	03091
	Physicia /Medic		1. Decedent's Name (First, Middle, La. George M. Thoma	ıs				2. Date of Death Month	Day Year 8 2005 4c. County of Death	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, given Salisbury Nursing 5. Social Security Number 6. S	and Rehak	Center (In yrs. last birtho		wn, or Location of Dea Salisbu Year If Under 24 Hr	ry, Md.	Wicomico	
	Funeral Director			M 2□F	78 Yrs	Months I	Days Hours Min		ear) Cou 1926 Mar	place (State or Foreign intry) yland
	Ba-f show	ctor	10a. State MD 10b. County Somerse	t	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	s 23a or 20 mat be no	Funeral Director	37 Wynfall Avenu			10f. Zip Ci	2181	7	J. Citizen of What Cou	
980	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Medical Exerting Item (1616) at	ক্র	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent I Amed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	51–73		it of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White Specify: Wh:	, etc.
21215-0036	within 72 hours ene. then "neturel", the Medical Exe	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(G	ecedent's Usual (Give kind of work of e. DO NOT use	done during most of w	orking unk 16	b. Kind of Business/Ir	,
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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif	y)/	cemetery,	isposition (Name crematory or othe	er place)		c. Location - City or T	
Bal	permit. Departi Importa any inju		21. Signature of general Sengre bicer 23a. Part Enter the disease, or/com	1/1/38	ector	Baltimo:	re, MD 212			
	Prrysician /Medical Examiner		shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a let	a consequence of)	en la	de de	ecor respiratory arrest		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and id for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):	forch	den.	and con		lan-
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	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Example one)	niner: On the basis of and manner sta	f examination and/o	or investigation, in	my opinion, death occ	e, and due to the caus curred at the time, date	and place, and due t	to the cause(s)
)	To To com	Σ	29b. Signature and title of certifier	Mas		6	DZ87	<u> </u>	Date signed (Month,	Day, Year)
	CA		30. Name and address of person who WITLIAM ROBINS, M. 31. Date filed (Month, Day, Year)	I.D. 200			BURY, MD.	21804	e 6	
	Sta Registr		FED 6 9 20		Le .	for the				

DHMH 17 Rev 1/2001

George Thomas

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			1 - For State Registrar	State of Ivia	rytariu		tificate				Glene Reg. No	4000	03092
	Physici	an	1. Decedent's Name (First, Middle, Las	t)	_					2. Date of De	ath Da	ay Year	3. Time of Death
	/Medic		BERNARD		VICT	ror			DVOSKIN	Thurm	20	7, 2005	
	Examin	er	4a. Facility Name (If not institution, give	Itmorc					ocation of Death	***************************************	40	c. County of Dee	
	Funeral		Social Security Number 6. S	7. Age	(In yrs. lasi	t birthday)	If Under 1	Year		8. Date of Bir	th		thplace (State or Foreign ountry)
	Director		210-07-1245	7 M 2□F	83	Yrs.	Months I	Days	Hours Min.	8. Date of Bir (Month, Da)2/12/1	921		MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
	Maryl -f sho	ţō	MD BALT	IMORE	BAL	OMIT	RE						1 ☐ Yes 2 No
	or 28a	irec	10e. Street and Number				10f. Zip C	ode			10g. Ci	itizen of What C	ountry?
	ath wi	rai	9 POMONA SOUTH AP					208_				U.S.A	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Department of Health and Menial Hygiene important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Example must be multilled at page.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Endered Forces? 1 MYes 2 Molif Yes, Give Year or Dates:			Was Deceder f Yes, specify		panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No Rican, etc.))-	14. Race - Ame Black, Whi Specify:	
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İ	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	plications that caused to	he death. I							,	Approximate Interval Between Onset and Death
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ב ב	The law rate has be page 2 sh	Completed	Alzhemer's Discon	SC						24a. Was auto perfo 1 Yes	psy rmed?	prior to death?	utopsy findings available completion of cause of
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	he Hospit n 24 houn ha Funera pletely fille	edical (29a. Certifier (Check only one) 2 Medicel Exem	ysician: To the best of liner: On the basis of and manner state	my knowle examination ed.	edge, death and/or inv	occurred at restigation, in	the time, n my opin	date and place, a dion, death occurre	and due to the ed at the time,	cause(s date an	s) and manner as d place, and due	s stated. e to the cause(s)
	with To t	Ž	29b. Signature and title of certifier					License n			29d. Da	ate signed (Mont	h, Day, Year)
	/		4 Wha	5 PO					-000		Jon	Jan 20	1,2005
	12		30. Name and address of person who of the which all the state of the s	completed cause of de	ath (Item 23	3a) (Type,	Print)	R	Ibasii	MD	212	2.1<	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signatur	e A	madi 1	1	11174516	· · · · · ·	-10	<u>د٠ -</u>	
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			For	State of Ma	aryland / De	partment	of Hea	alth and M			gible.	0200	Ó
			State Registrar			ertificate	of De	eath		Reg. No.	000	0309	Ü
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	neral ector		5. Social Security Number 6. Se 219–38–9095	9x 7. Ag ☐ M 2 X F	e (In yrs. last birthd	Months		Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Jan. 14	y, Year)		place (State or Foreigntry) Land	зп
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the Mai	rodiffed	Funeral Director	Maryland Baltimo	ore	Art	outus 10f. Zip (Code			10g. Citizen	of What Cou	1 ☐ Yes 2📆 N entry?	0
th with	34 O	a D	1807 Sutton Avenu	ıe			212	27			U.S.A	١.	
r deat	EL DIE	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede	ent of Hispa fv Cuban, N	nic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amen Black, White		
d 21215-0036 filed within 72 hours after death with the Maryland Hyglene, therein or flams 23a or 28a-f show	item 2/18 marked other than "neture", or nems 23e or 20e-1 show other treumatic event, the Mudical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 1 If Yes, Give Year or Dates:	No	1□ Yes Z		Specify:			ecify:	nite	
Maryland 21215-0036 of 2 should be filed within 72 hours aft this and Mental Hyglene.	Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(G	ecedent's Usual Give kind of work fe. DO NOT use	Occupation done during retired)	n ng most of work	ing	16b. Kind	of Business/Ir	ndustry	
2 yglen	t, tte	Con	12		I I	Home Mal			4000		Own H	lome	
Taryland 212. 2 should be filed within and Mental Hyglene and marked other than	ed off	Be	17. Father's Name (First, Middle, Last) Peter Schoenbrodt				18	. Mother's Nam Olga Go	e (First, Middle, o.11in	Maiden Sui	name)		
should be	matic	၉	19a. Informant's Name/Relationship (1		19b. M	ailing Address	(Street and			er, City or To	wn, State, Zi	o Code)	
e, Ma 1 and 2 s Health ar	27 IS		Alfred G. Volkmar		2400	Daphne	e Lane	e Alexai	ndria, V	Vir in	ia 223	06	
of Hei	r othe	_ @	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State	20h Place of Di	isposition (Nam.	e of		Date	100	on - City or T		
Page ment	ury o		*4 ☐ Donation 5 ☐ Other (Specify	')	St. Pau Church	crematory or oth 11 Luthe Cemeter	eran	2-2-2		Violet	ville,	Maryland	
Baltimore, Manager Pages 1 and 2 Department of Health a monotract if them 27 in	eny in		21. Signature of Funeral Service Licen	see and	1	Witzke 1630 Ec	Funes Funes Imonds	f Facility ral Home son Avei	e of Car	tonsvi onsvil	lle, I	nc. 21228	
Dhua	ician		23a. P. rt1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	one cause on each li	the death. Do not ne. NîRAC	enter the mode	of dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	dical		disease or condition resulting in death)	u	a consequence of):		,,,	ELEINIC	CICITA	GE	-	4 DAYS	
Exam	niner	_	Sequentially list conditions,	b. Due to lor as	a cons quence of								
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68 difficate	ng phy as the		IF FEMALE:	. •									-
I Records, P.O. Box 687 The law requires that the death certificate	been signed by the attending physis should be detached for use as the t	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pre 5 ☐ Other (spe				23d	Date of deliv Month	ery Day Year	
IS, P.O.	igned by be detac	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in th	ne underlying ca	use given i	n Part I.		-		the cause of death?	
Ord requi	hould	eted			-				1 []	-			
i Rec	ate has t page 2 s	Completed							24a. Was autor perfo		4b. Were auto prior to co death? 1 ☐ Yes	opsy findings availab empletion of cause of Mo	le
/ita	certificate rector, pag	Be (25. Was case referred to medical examiner?	Hospital:			Othors		h (Check only o				
Of V	this cral dir	To.	1 Yes 2 No	Hopatii	ent 2 ER/Outpa /ry 28b. Tim		Other:	4 Nursing Ho	me 5 Resident			fy)	_
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Division of Vital Records, for Attending Physicien: The law requires the affect Geath.	Director in by the	Certification:	3 Suicide 6 Could not be determined		jury - At home, farm tc. (Specify)	, street, factory,	office		28f. Location (City or To	Street and N wn, State)	umber or Rur	al Route Number,	
Division of Vita To the Hospitel or Attending Physicien: Whitin 24 hours after death of the Attention or file.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examination and/o	feath occurred a or investigation,	it the time, in my opini	date and place, on, death occur	and due to the red at the time,	cause(s) and date and pla	1 manner as s	stated. to the cause(s)	
Fo the vithin 2	Fo the comple	Mec	29b. Signature and title of certifier	GIVE HIGHINGI SC		29c.	License nu			29d. Date s	gned (Month,	Day, Year)	
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	10		Dr. SArum	completed cause of	meath (Item 23a) (Ty	OSPITA	2	BALT	mor	e, n	1000	21229	
- A	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	to ath (Item 23a) (Ty the Nt3 H rar's Signature	Sporte							

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Damien Varga/son Damien Varga	Z		de de	Š	17. Marital Status 12. Was Decedent of Hispanic Origin? (Armed Forces? If Yes, specify Cuban, Mexican, Pue	orto Rican, etc.)	
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Damien Varga/son Damien Varga	3	Ş	ture hou	ed	15 Decedent's Education 16a Decedent's Usual Occupation	16	th Kind of Business/Industry
Damien Varga/son Damien Varga	\geq	15	In 72	plet	(Specify only highest grade completed) (Give kind of work done during most of w	orking	b. Nind of business industry
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Damien Varga/son Damien Varga		2	shou mar mar	-			City or Town, State, Zip Code)
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Due to (or as a consequence of): Professional and prof		ē,	Hea Hea Item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or Town, State
23. Part I. Cher the datase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Control Con		9	age: ent o nt: If		1 Durial 2 Cremation 3 Removal from State		
23. Part I. Cher the datase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Control Con		喜	artmoortar ortar injur		21 Signature of Europea Service Licenses 22 Name and Address of Spailib.	<u> </u>	
23. Part I. Cher the datase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Control Con		Ba	Ped of the state o		Anthony D. Pleasant State Anatomy Boar	rd 655 W. 1	Baltimore Street
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Due to (or as a chrisequence of): Comparison Compari			uted a ansit	듵	cause. Enter Underlying Cause (Disease or injury Serial (Serial Cause)	1011	
FEMALE: 23c. If yes, outcome of pragramy 23d. Date of delivery Month Day Year		÷	n and	Еха	resulting in death) Last Due to (or as a consequence of):	V // //	WET CAL EXAMINES
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OC A 19 September 20 September		X	ndini use a	N/	23b. Was decedent program 23c. If yes, outcome of pregnancy		23d. Date of delivery
25. Was case referred to medical examiner? 10			death s atte	cla	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month Day Year
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25. Was case referred to medical examiner? 10	,	Re	The la	E	d was sized out	performe	d? death?
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State		_	0			wat tou	www miss
					31. Date filed (Month, Day, Year). JAN 2 7 2005		

State of Maryland / Department of Health and Mental Hygiene Reg. No. U 0 5 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) Month Physician BONAPARTE ARDELL APOL EON 6:30 AM TAN /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner 8. Date of Birth Month, Dey, Year) SQUARE HEALTH AND REHAB. CENTER BAL TIMORE RANKLIN If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 12 M 2□ F 9. Birthplace (State or Foreign 5. Social Security Number 202-14-7193 7. Age (In yrs. last birthday) **Funeral** Days Yrs. 25 PENNSYLVANIA Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARILLAND 10e. Street end Number 10g. Citizen of What Country? USA AVETTE Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2D-No Specify: Specify: BLACK Be Completed by 3. Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) OPERATOR 2THGRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (FEORGE W. SR. MINNIE MAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name of Date 20c. Location - City or Town, State DONALD WARDELL (BROTHER) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VA. CEMETERY 02-05-05 CROWNSVILL 22. Name and Address of Fecility 21. Signatore of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heert feilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or as e consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ⊠No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No nours after deeth.

neral Director: After this

filled in by the funeral di this 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Menner of Death 28b. Time of Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 I Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of elamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stand. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Hungrand Perry Rel 27/7 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 16 Rev 6/95

				_ ror	Department of Health and M Certificate of Death		iene 005 03096
		Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	
		/Medic Examin		Herbert Webster 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1/3/4/2/3/	4c. County of Death
		- Admini	Ŭ.	MORTHARUNDRU HORPITA	CIENBURNIE		ANNE APUNIDEL
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 163-44-7893 2 5 2	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, SEP 27	9. Birthplace (State or Foreign Country) Pennsylvania
				Usual Residence of Decedent		DDI 27	
		ith the Marylan or 28a-f show	j.	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
		the M	rect	Maryland Baltimore C	atonsville	10	0g. Citizen of What Country?
>		h with	al Di	6219 Frederick Road	21228		USA
Ž		tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Websta	36	within 72 hours after death with the Maryland nea. than "natural", or items 23a or 28a-f show than "natural" or items 23a or 28a-f show on Maryland at the natified at	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 🔼 No If Yes, Give 3 □ Widowed 4 况 Divorced Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify: Black
le	21215-0036	72 hou		15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	na 1	16b. Kind of Business/Industry
3	121	within one. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give kind of work done during most of work) life. DO NOT use retired) Social Worker	i	State of Maryland
+	d 2	filed v Hygie other 1	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name		
lerbert	Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla t of Health and Mental hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f ahov or other traumatic evant, Ite Medical Examiner must be notified all	To Be	Dwight Herbert Webster	Helen	Walker	
3	/Jan	2 sho and f			Mailing Address (Street and Number or Rura		MD 20906
6		s 1 and 2 of Health a item 27 is other trace	1				t. 13, Silver Spring, 20c. Location - City or Town, State
T	ē	Pages nent of l int: if it		1 Bunal 2 X Cremation 3 Removal from State	Crematory, Inc. 2/2/	05	Baltimore, MD
	3altimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of up al 5 rvice Licensee?	22. Name and Address of Facility Cremation Society o	f MD. In	nc .
		20 E 2 3		Edward A. Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do r	299 Frederick Road	Baltimor	e, MD 21228
_		7		shock, or heart failure. List only one cause on each line.			Interval Between
•		Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the conseque		- M - M - M - M - M - M - M - M - M - M	Y (A -
		Examiner	_	Sequentially list conditions, b.			
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or):		
	oʻ	ate be executed hysician and the burial-transit		that initiated events c	of):		
	8760,	ate hy	by Physician/Medical	d			
4	9	eath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
,	Box	death of attended for u	lcian	250. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
	P.0	that the death ed by the atte detached for	phys	9 ☐ Unknown			
		8 6 9		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		pacco use contribute to the cause of death?
	of Vital Records,	w requir been si should	Completed			24a. Was an	
	Re	The lav	ошр			autopsy perform	24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☑ No
	/ital	i cien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	(Check only one	θ)
	of \	Physicie this cert	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou			nce 6 Other (Specify)
		nding Phrith.: After th	ation		Time of njury at Work? M 1 Yes 2 No		
	Division	r Attai er dea rector i by th	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, n, State)
		pital o	O	Constitution Developer To the heat of true learned day	death accurred at the time data and place	and due to the en	(a) and manage as shall
		To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to	ledical	29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination an and manner stated.			
		To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
		\ -		1 Shedy	10 195149		JANUARY 31 2005
		φ		30. Name and address of person who completed ause of death (Item 23a)		wsup	mi> 210 61
		Sta	ate	31. Date filed (Month, Bey, Year) 3 2005 32. Redistrar's Signature A			
		Regist	rar	LED A COOL			

CPM 05-00789 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cynthia Blackwell State of Maryland / Department of Health and Mental Hygiene State RegionPEND & Amend item#1,23a,27&28 Gertificate of Death 3/25/05 JH Reg. No. ent's Name (First, Middle, Last) CYNTHIA LORRAINE BLACKWELL WALCOTT 3 Jime of Death Day 30 **Physician** 2005 January 18:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3000 block Reisterstown Road Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 217-78-0275 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
and: If items 22 le marked other then "natural", or Items 23e or 28e-1 show and it if items to lemmarke to the traunatic event, ite Medical Examinations to the traunatic event, ite Medical Examinations. Yes 2 ☐ No Completed by Funeral Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. dent Ever in U.S. Forces? 2 Married Yes 1 Never Married Baltimore, Maryland 21215-0036 1□ Yes 2☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (0-12)College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Graham. ဥ Informant's Name/Relationship (Type, Print) 19b. Mailing ddress (Street and Number or Jural Roule Number, City or To Walcott Department of Health a Important: If itam 27 Is any injury or other tra once. 5000 Kensterston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Greene Funeral Services andallotorun MD21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fawure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MIXED DRUG INTOXICATION COMPLICATED BY HYPOTHERMIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause End Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Jyes 2 □ No detached (he 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No autopsy performed? certificate Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 XYes 2 □ No P 4 ☐ Nursing Home 5 ☐ Residence 6 XX ther (Specify) SCENE this After thi funeral of 28a. Date of Injury **four M** nth, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending .nvestigation found death. 1 ☐ Yes ▼☐ No JAN 30 2005 6:30p 128e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN 2 Accident within 24 hours after deat To the Funaral Director: Could not be determined 3 Suicide in by t 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3000 BLK of 4 Homicide SCENE REISTERSTOWN RD. BALTO.MD To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature_and title of certifier

29c. License number

29d, Date signed (Month, Day, Year)

O.C.M.E.

January 31, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panela E. Sxithall, MI

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar

2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registre AMEND ITEM #9 PER FH G8402/03/05/ifigate of Death Reg. No. 2. Date of Death Month 29 4:30 AM **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFURD Baltimore ictoria 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months MD 1 □ M 236-32-1929 Yrs. Director N.C Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Modical Examination was be mailfied at 1 TYes 2 No Director Kattimore MUIFORD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Wenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) ustodian Katto. Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be rmoson 19b. Mailing Andress (Street and Number or Renal Route Number, City or Town, State, Zip Code) e/Relations ip (Type, Print) Victoria permit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Mill 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition → Burial 2 Cremation 3 Removal from State Baltimore -3-05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C Greene Fundral Snc. 21. Signature of Funeral Service License David berty Road Kandallotown MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Stage Metastatic Physician resulting in death) /Medical Due to (or as vonsequence of): Examiner ertension Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit Sicondaru to Cerebralan eu nom as a consequence of): signed by the attending physician a d be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 parotitis cacheric 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Right hemiplegia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? filled in ty the funeral 28b. Time of After Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Dire ctor: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide or latte within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medi al Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type. Keill 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 2005 Registrar

			1 - For State Registrar	State of Maryland		ent of Health			iene	005	030	99
I	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) ARY 4a. Facility Name (Il-not institution, give s	Ldven	4b. (Dity, Town, or Location		2. Date of Deat Month	Bay	Year 05 County of Death	3. Time of 1/55	Death M M
	Funeral Director		5. Social Security Number 6. Sex	HOMEWOOD M 2XIF 7. Age (In yrs. last	t birthday) If U Yrs. Mon		RE CIT der 24 Hrs. rs Min.	Y 3. Date of Birth (Month, Day, 04/03/		J / Z	nplace (State of untry) RGINIA	
	ith the Maryland or 28a-f show e notified at	tor	10a. State 10b. County MD BALTIM		own or Location	ILLE					10d. Inside Cit 1 ☐ Yes	
	h with the 23a or 28 st be not	al Director	10e. Street and Number 717 EAST SHIRE	DRIVE	101	. Zip Code 2122	28	1	0g. Citize	en of What Co	untry?	140
020	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show ta Modeal Exemiter must be notified a	by Funeral	11. Marital Status 1 1 Never Married 2 Married XXWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		ecedent of Hispanic specify Cuban, Mexi is 2 🔀 No Spec		ify Yes or No- ican, etc.)		4. Race - Ame Black, White Specify: BL	e, etc.	
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Jana zi	be filed ntal Hygi od othar avant, I	To Be Cor	12TH 17. Father's Name (First, Middle, Last) WILLIE GLEN	N SR.	LAUN		other's Name (First, Middle, M	IURS Maiden S		HOME	
e, mar)	s 1 and 2 should of Health and Mer itam 27 Is marke other traumatic	·	19a. Informant's Name/Relationship (Type JACKIE GLENN / 20a. Method of Disposition	GRANDDAUGHTE		ress (Street and Nur EAST SH		R, CAI	ONS		, MD 2	1228
	t. Page rtment o rtant: If vjury or		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify) 21. Signature of uperal Service License	emoval from State LOU	otery, crematory DON PA	or other place) RK CEM. e and Address of Fa	02/0	5/05	BAL	TIMOR	E, MD	0.7
Ö	permi Depa Impo any ir		23a. P. A. merthe s ase, or complice ship ck, or heart filtere. List only on	8. Rown	460	0 LIBERT	Y HEI	GHTS A	VE,		IMORE,	MD
,0070	Physician // Medical Examiner percented the private ransit from the private ra	Jical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	Tender of):	durese		A15Cc1			Interval Betwonset and E	Death
O. Box o	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	eath 3 Ector	ic pregnancy r (specify)			23	d. Date of deli Month	,	'ear
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DIVISION	To the Hospital or Attanding I within 24 hours after death. To tha Funaraf Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				Bf. Location (St. City or Town	, State)			per,
	the Hosp thin 24 ho tha Funs mpletely fi	Medical	29a. Certifier (Check only one) 2 Medical Examir 29b. Signature and title of certifier	ician: To the best of my knowle ar: On the basis of examination and manner stated.	edge, death occu n and/or investiga	rred at the time, date tion, in my opinion, of 29c. License numb	death occurred	d at the time, da	ate and p	nd manner as place, and due signed (Month	to the cause(s)	
	T T S		30. Name and address of person who co	2 Mo	3a) (Tuna Diri)	D00596		2	1/3	1	., Day, 1881/	
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	/Medic Examin		4a. Facility Name (If not institution, g			4b, City, Town, or Location of Dea KandallStown		4c. County of D	
	Funeral Director		212-24-8234	Sex 7. Age (In yi	rs. last birthday) 1 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		y, Year)	Birthplace (State or Foreign Country) MD
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	th the or 28, and a	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of Wha	
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Ball	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a Once.		21. Signature of Funeral Service Lic	te K-Im	Ma 43	rch F/H West 00 Wabash Ave	, Balti	more, Mo	21215
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	/Medical Examiner		rooming in doutry	Due to (or as a cons	sequence of):				
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oʻ	e exec ian ar urial-tu	Exc	resulting in death) Last	Due to (or as a cons	sequence of):				
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Division	E Sign	Certification;	4 Homicide determin		at nome, tarm, stri ecily)	eet, factory, office	City or To		r Rural Route Number,
	To the Hospital or Attan within 24 hours after deatl to the Funeral Director: completely filled in by the	edical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my caminer: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
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			10	Keins M	D	D44505		JANKAR.	431,2008
	14x1		30. Name and address of person w	ocombleted cause of death ((Item 23a) (Type,		ilus a		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Register's Si	ignature &	Recelle D	3 00 4 C		
	Regist		FEB	3 2005 ▶ See	per Do	The same of the sa			

			_ State	and / Department of Health and M Certificate of Death	
			Registrar 1. Decedent's Name (First, Middle, Last)	Commodite of Death	2. Date of Death 2. Three of Death
	Physicia /Medic		MARY ELIZABETH WALTER		FEBRUARY 1, 2005 3:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Francis		LORIEN FRANKFORD NURSING HO 5. Social Security Number 6. Sex 7. Age (In)	ME BALTIMORE vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year). 9. Birthplace (State or Foreign Country)
	Funeral Director		212-01-8782 ¹□M ¾□F	86 Yrs. Months Days Hours Min.	(Month, Day Year) Country) 9–21–1918 MARYLAND
	put		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limits
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	th the or 28a e notii	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wil	rai D	1500 ROSEWICK AVENUE	21237	U.S.A.
36	172 hours after death with the Maryland "natural", or Itema 23a or 28a-1 show dical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☒ No Specify:	ncify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
5-0036	Phour	ed b	3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workit life. DO NOT use retired)	ng
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aryl	should and Menia s marke	Ě	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	I Route Number, City or Town, State, Zip Code)
	1 and 2 Health a lem 27 Is		CLARA STRICKROTH/DAUGHTER	the state of the s	JREL, DELAWARE 19956
Baltimore,	permit. Pages 1 and i Department of Health Important: If Item 27 any injury or other tr once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)	20c. Location - City or Town, State
Ħ	permit. Pag Department Important: I any injury o		*4 □Donation 5 □ Other (Specify) 21. Signature of Futteral Service Licetisee	HOLLY HILL MEMORIAL 2-4-2	2005 MIDDLE RIVER, MD ACH/ROSEDALE FUNERAL HOME
Ba	permit. Departr Importa any inji) Shart		E ROSEDALE, MARYLAND 21237
			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	Jeath. Do not enter the mode of dying, such as cardiac o	Interval Between
	Priysician		Immediate Cause (Final disease or condition	ren's Dementa	Onset and Death
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000	s beer	piete			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Re	: The law cate has l	Com			autopsy performed? death? 1 ☐ Yes 2 ☐ No
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
of	Phys this ral dis	. To	1 Tes 2 No 1 Inpatient		ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
lon	Attending r death. ector: After by the fune	ation	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Yea	ur) Injury Work? M 1 ☐ Yes 2 ☐ No	
Division	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Sp		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ours a		29a. Certifier Certifying Physicien: To the best of my	knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated
	n 24 h	edical	(Check only one) 2 Medicel Exeminer: On the basis of examiner and manner stated.	mination and/or investigation, in my opinion, death occurre	ed at the time, date and place, and due to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			1 / / / / / / / / / / / / / / / / / / /	W mo 13386	2.2.05
	7		30. Name and address of person who completed cause of death		Bultimore WA 21201
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year) 32. Resistrar's S	Signature M. Acade a	
	Regist		ED US 2005	K Basel a	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Month 5,55 AM **Physician** Grace S. Williams tebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deat **Examiner** Arundel HOSPITA If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** . 1932 Days Months Hours Country) Maryland 1 ☐ M 2**X** F 219 28 9291 72 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f ehow treumetic event. The Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 758 - 219th Street U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: in and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Ticketmaster Theatre 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Cooper Willard Gray Rush 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an John Williams / Husband 758 - 219th Street Pasadena, Maryland 21122 Health other Her 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 2/4/2005 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 nancia 23a. Part1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each lin Small GU Immediate Cause (Final Lung (ancer Priysician disease or condition resulting in death) /Medical **Examiner** ulmonau hvonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed neum onia use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After To the Hospitel or Attending Natural 5 Pending М 1 🗌 Yes 2 🗆 No death. investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar FEB 0 3 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Rem 23a) (Type, Print)

h 14 MD

D41365

Hospital

Drive Glen Burnie, MD. 21061

ORIGINAL

			For State Registrar	State of Maryland / Departi Certifi	ment of Health and Micate of Death	lental Hygiene	4000 00103
	Physicia		Decedent's Name (First, Middle, Last) EMMO	WEBR		2. Date of Death Month Day	3. Time of Death
	/Medic Examin	-	4a. Facility Name (If not institution, give s	treet and number) 4b	City, Town, or Location of Death		. County of Death
	Funeral Director		210 1000 10		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
	show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits 1 ★ 6s 2 □ No
	vith fhe N or 28a-f be notiff	Director	10e. Street and Number	, 1	0f. Zip Code	10g. Cit	tizen of What Country?
	ms 23e	Funerai	1931 E. Jef		21205 Decedent of Hispanic Origin? (Spens, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
920	hours after death with the Maryland lurel', or Items 23a or 28a-f show at Examinar must be mailfied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No	yes 25 No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
21215-0036	"na"	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give kind	's Usual Occupation d of work done during most of works NOT use retired)	ing	(ind of Business/Industry
	D D = -		17. Father's Name (First, Middle, Last)		Domestic		leaning
Maryland	should be file nd Menfal Hyg marked othe umatic evant,	To Be	James M		Hatt		ckler
Mar	d 2 th a tra		19a. Informant's Name/Relationship (Type Evelyn Richard	The department of the contract	ddress (Street and Number or Rura	Dr. Bath	
ore,	ges 1 f of H if ite or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	20b. Place of Disposition cemetery, cremator	on (Name of ory or other place)	. 1 2	ocation - City or Town, State
Baltimore	nit. artm orta Inju		*4 □ Donation 5 □ Other (Specify) 21. Signature uneral Service License	Mount 22. No	ame and Address of Fagility	Tineval	ndsdown, MD
8	Per Impo	()	ame he	and !	712 3 vd St.	V.W. Wa	services. Inc.
	Pnysician		Immediate Cause (Final	cations that caused the death. Do not enter the cause on each line.	ne mode of dying, such as cardiac o	or respiratory arrest,	proximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due as a consequence of):	THOMOCHON		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a course of):	itery or	sease	
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760,	cate be ex ohysician the buria	dical E		1.			
Box 68	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medi	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec	topic pregnancy		23d. Date of delivery
.O. B	fhat the deaf	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		her (specify)		Month Day Year
s, P	ig bed	by	Part II. Other significant conditions cor	ntributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Record	The law requirate has been spage 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital		BeC	25. Was case referred to medical examiner?	Land hali		h (Check only one)	73.733 22.70
of	d is	7: To	1 Yes 2 No	28a. Date of Injury 28b. Time of	28c. Injury at	ome 5 Residence 28d. Describe how inju	
Division	Attending I death. ctor: After y the funer	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Work? M 1 Yes 2 No		
Divi	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my knowledge, death oc ner: On the basis of examination and/or investand manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
•	, \		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Prin	03 376 2	-	212103
1	7		Jude Myneses	mD 7845	Dakwood Re	mad Glen	Burnie mo
	St: Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 3 201	ompleted cause of death (Item 23a) (Type, Printing	dist.		

ORIGINAL

К	1- For Unpend Item 23a,27,28a f per me Cert	tpentof Health and Mental Hygiene	
q	Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	3. Time of Death
Physician /Medical	Christian Omar Abrego	January 23	3, 2005 4:51 P ^M
Examiner			: County of Death
	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Date of Birth	ontgomery
Funeral Director	217-61-2646 Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year, 5/11/19)	
Maryland a-f ahow ified at	MD 10b. County 10c. City, Town or Local Montgomery Kensing		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
other death with the Marylar ritems 23a or 28a-f show the control of the control	10e. Street and Number 12320 Charles Road	1	tizen of What Country? . Salvador
036 urs after dea	1 TvNever Married 2 ☐ Married 1 ☐ Yes 2 TvNo	as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 no Specify: El Salvador	14. Race - American Indian, Black, White, etc. Specify: White
는 a 13 등	(Specify only highest grade completed) (Give kife. D.	ont's Usual Occupation 16b. If and of work done during most of working O NOT use retired)	Gind of Business/Industry
tal Hy doth	17. Father's Name (First, Middle, Last) Pablo Lopez	18. Mother's Name (First, Middle, Maidel Martina Abrego	n Sumame)
should be not Menta marked matic ev		Address (Street and Number or Rural Route Number, City	
and 2 s saith an 27 is		20 Lockwood Drive Silve	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men important: If them 27 is marke any injury of officer traumatic once. To	20a. Method of Disposition 20b. Place of Dispos	ition (Name of atory or other place) Bar	cation - City or Town, State tolome Perulapia Salvador
Baltil Permit. I Departm Importal any inju	21. Signatur of Funeral Service Consee	Name and Address of Facility HILIP D.RINALDI FUNERAL 241 Columbia Blvd.Silve	SERVICE.P.A.
ate be executed ate be executed itysician and ithe burial-transit the burial-transit	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Acute Alcohol Into Due to (or as a consequence of): Due to (or as a consequence of): C	xication	
icate be physicial sthe burner adleal	d		
Box (death certification) death certification of for use a lician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
rds, P.O ruires that the In signed by the Ind be detache Ind by Phys	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death?
Division of Vital Records, or Attending Physician: The law requires the death. Director, Hether this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by		24a. Was an autopsy performed? 1 1 A Yes 2 □ N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ysician: Thy ysician: The secutificate director, pag	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of V physic this o al dire To	XXYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		
Division of Vital tal or Attending Physician: rs after death. rs alter death all Diractor: After this certification to Be Certification: To Be C	2 Accident 1-23-05 4:15	Work? 1 □ Yes 2 ▼No	and Number or Rural Route Number,
DIVI pital or At urs after of aral Dirac illed in by	4 Homicide determined building, etc. (Specify) Found At Residence	Kensington	, Maryland Rd.
Division To the Hospital or Attention within 24 hours after death to the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Exeminer: On the basis of examination and/or invariant manner stated. 29b. Signature and title of certifier	estigation, in my opinion, death occurred at the time, date ar	
To Too	296. Signature and title of certifier M.D.	_	uary 24, 2005
		Penn Street, Baltimore, Ma	
State Registrar	31. Date filed (Month, Day, Year) JAN 3 1 2005 32 Registrar's Signature	di)	

		-	For State Registrar	State of Ma	aryland	•	artmen rtificat					giene Reg. No.	005	03106	
	0		1. Decedent's Name (First, Middle,	ast)	`						2. Date of Dea Month	ath Day	Year	3. Time of Death	_
	Physicia /Medic		Geo	orge Robert	Adams	, Jr	•				JANUARY				
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location	of Death		4c. (County of De	ath	
			20378 GILLIAM DR	IVE				K HA				ST	.MARY'	S	
	Funeral Director		212-76-7809	Sex 7. Ag	e (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da March 23	y, Year)		irthplace (State or Foreigr Country) ryland	1
	pug *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Fown or Le	cation							10d. Inside City Limits	_
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	tor	Maryland Saint N	larvs		Hollyv								1 ☐ Yes 2 ☑ No	
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?	
	23a 23a	ai	24467 McIntosh Road				2	20636				U	SA		
	ems ermi	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	. 1	4. Race - Am Bfack, Wh	nerican Indian,	
36	or It		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🔯			1 ☐ Yes		Specify:				Specify: Wh		
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:											_
5	"nat	lete	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Usua kind of wo DO NOT us	af Occupa rk done d	ation Ju <i>nng m</i> os	st of work	ing	16b. Kin	d of Busines	s/industry	
21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12) 12	College (1-4or :			/Operat		,			Cor	nstructi	ion	
9	Hygi Hygi ther		17. Father's Name (First, Middle, La	st)		OWITCE	operat		18. Mothe	er's Nam	e (First, Middle,			LOII	_
Maryland	should be filed and Mental Hygi s marked other umatic event, I	To Be	George Robert Adam	S. Sr							eline Mat				
<u> </u>	2 shoul and Me Is mark	ř	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a			al Route Numbe			Zip Code)	_
<u>∞</u>	Ith a		Donna M. Adams / Wi	, , ,							ood, Mary			-,,	
ē,	~ T & 5	1 8	20a. Method of Disposition		20b. Plac	e of Dispo	osition (Name	ne of			Date ruary			or Town, State	
90	m O .		1 🖫 Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		Char	les M	emoria]	L Conde	9)		2005	Leon:	ardtown	, Maryland	
Baltimore,	그는만구	1	21. Sign xu e of Funeral Service Lie			2:	2. Name an	d Addres	s of Facili	ty				, mary rama	
ä	Depa Impo any ir		M school Kein	in Tarde			_	_			eral Home wn, Maryl	-			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death.								3030	Approximate Interval Between	
	Pnysician :		Immediate Cause (Final disease or condition	1	essio	100	Ara	x 2 - 10		1 w d	Chost	7 11	1000		
	/Medical		resulting in death)	aDue to (or as			112/	MX	i a v	ruer	-C1021	+1	farie	1	
b	Examiner		Coguantiathy list conditions	b									~		
-	n =	ner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a curiseque	nce of):									
	pate be executed only sician and the burial-transit	Examiner	that initiated events	c										<u> </u>	
Ő,	e exectan a		resulting in death) Last	Due to (or as	a consequer	nce of);									
8760,	ate b	lica		d.											
9	death certifica attending ph d for use as th	Physician/Medical	IF FEMALE:	22a litura autaoma	of account										
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	eath 3	⊒Ectopic pi					2	3d. Date of d Month	elivery Day Year	
0	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of deaf	th 5L	Other (sp	ecify)						,	
0	that the died by the detached		Part fl. Dther significant condition	s contributing to death b	out not resulti	na in the u	ınderivina c	ause give	en in Part I	l.	23e. Did to	obacco us	se contribute	to the cause of death?	
ecords,	Se de	d by				,	. , ,				10	1	1	Probably 4 Unknown	ł
Ö	w requir been si should	Completed					_				24a. Was	an	24h Wara	autopsy findings available	_
Re	The lav	E D								-	autop		prior to depth?	completion of cause of	•
a	<i>ia □c</i>	e Co	25. Was case referred to medicaf	7					00 01	1 D 1	1/ Yes	2□ No	1 🔼 Ye	es 2 No	
Vital		00	1 Xes 2 No	Hospital: 1 ☐ Inpati	ant 2 🗆 E	2/Outpatio	nt 3 🗍 DC	Oth			h <i>(Check only d</i> ome 5□ Resid		Tital has (C-	conta COENTE	_
of		. To	27. Manner of Death	28a. Date of Inju	ury 2	8b. Time o		28c. Injury	at	ursing no	28d. Describe I			pecify) SCENE	
O	th. : After funera	tio	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year)	Injury	Рм	Worl 1 🕱		No	Tree	fel	1,805	unject	
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 □ Could no		jury - At hom	e, farm, st	reet, factor	y, office			28f. Location (Street and	Number or I	Rural Route Number.	
ē	afor s afte	Certification;	4 Homicide	OU.	tside						Park K	Wall	20378	Gilliamir.	
	To the Hospital or Attent Within 24 hours after death To the Funeral Director: Completely filled in by the	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner si	of my knowled	edge, dea	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s)	and manner a	as stated. ue to the cause(s)	
	o the	ĕ.	29b. Signature and title of certifier				290	c. Licens	e number			29d. Date	signed (Mo	nth, Day, Year)	
	COL		D CAMARIA	410 an	hid			0.0	יד זאן י			T A 1.TT T A	DV 20	2005	
	340		30. Name and address of person w	ho completed cause of	death (Item 2	3a) (Tvpe	. Print)	0.0	M.E.	•		JANUA	RY 28.	, 200)	
	the		CAROL H.	tuANN	col	,,,-		ENN	STREI	ET B	ALTIMORI	E,MAR	YLAND	21201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	far's Signatur	re	25								
	Regist	rar	JAN 3	I SOND	Jagres .	as of the	Contract of the second	1							

			. For	State of Maryland	d / Depa	artmer	t of He	aith ar	nd Men	tal Hyg	iene	
			- State Registrar		Cei	rtificat	e of D	eath			g. No. 200	5 03/07
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)						ate of Deat Jonth	h Day Yea	
	/Medic		Adesewa	Akinseye			*			nuary		10:54 P
	Examin	er	4a. Facility Name (If not institution, give Southern Marylan				Town, or L	ocation of L	Death		4c. County of De	
	Euperal	7	5. Social Security Number 6. S	/-	ast birthday)	If Unde		if Under 24	Hrs. 8. C	ate of Birth Wonth, Day,		George s inthplace (State or Foreign Country)
	Funeral Director		578-15-1301	□M 2 💆 F 20	Yrs.	Months	Days	Hours				shington, DC
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	nation						10d. Inside City Limits
	anyla ehov	5	District of Colum		Washin							ty⊡ Yes 2 □ No
	the N 28a-f	ect	10e. Street and Number				p Code			1	0g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f ehow rmust be natified at	Funeral Director	1630 Lincoln Roa	d. NE			0002				United St	ates
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece	dent of Hisp	panic Origin	n? (Specify Puerto Rica	Yes or No-		merican Indian,
0	or Its		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes		Specify:	. donto / nod	., 0.0.,		Black
3	filed within 72 hours after Hygiene. other than "natural", or Ite sont, the Medical Examina	d by	3 Widowed 4 Divorced	Year or Dates:								
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and	be filed tal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (Fir	st, Middle, I	Maiden Surname)	
/lai	should bond Menta	2	Oluwafiropo Akin	seye			<u>`</u> _		Ajoke			
lan	2 sho and ts m		19a. Informant's Name/Relationship (**	1	•					City or Town, State	
≥ o`	l and leatth om 27 ther tr		Oyin Akinseye - 1 20a Method of Disposition		103U			1, NE	Wash1	-	DC 2000 20c. Location - City	
baltimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heath and Mental Hygiene. ortant: if Item 27 is marked other than "natural; or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinating the maillied at injury or other traumatic event, the Medical Examinating the maillied at		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	matory`or	other place)	- 1			•	
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g	Department of the property of		John C	to Tant T							ington, D	
Е			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death								Approximate Interval Between
f I	Physician		Immediate Cause (Final disease or condition	a. Bronch		101.	10 Cm	i d				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		104	more	10	-			
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ŏ	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		⊒Ectopic i	reanancy				23d. Date of	•
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Sec	has b	mpi	Wringry /re	sof Intecto	80	/				24a. Was a autops	sy prior	autopsy findings available to completion of cause of 1?
	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					OC Place	of Death (Cl		2 No 154	'es 2□No
Vita	Physician: r this certificatal director, i	O B	examiner? 1 Yes 2 No	Hospital: 1 Hapatient 2	ER/Outpatie	ent 3□ 0	Other	P		-	ence 6 Other (S	Specify)
o	g Phys er this teral dir	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		28c. Injury Work	at			ow injury occurred	p. 0.17)
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	To the Hospital within 24 hours To the Funeral completely filled	edical		hysician: To the best of my kno miner: On the basis of examina and manner stated.								
	o the o the	Mec	29b. Signature and title of certifier	and mariner stated.		2	9c. License	number		- 2	29d. Date signed (M	onth, Day, Year)
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	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture	`	()	//	VI); Y		20 70	~
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			Decedent's Name (First, Middle, Last)				2.	Date of Death		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give	BEACHLEY street and number)		4b. City, Town, or Lo			c. County of Deat	
			210 SUNBROOK LANE			HAGE	RSTOWN		WASHI	NGTON
	Funeral		5. Social Security Number 6. Sec				f Under 24 Hrs. 8. Hours Min.	Date of Birth 2	16/239. Birt	hplace (State or Foreign buntry)
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinational be notified at one.	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
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ထ			1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No	1	If Yes, specify Cuban, I		an, etc.)	Black, Whit	e, etc.
Ö		<u>5</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 反 No S	Specify:		Specify:	WHITE
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Ž		ဥ	ALVEY AUSTIN BEAC 19a, Informant's Name/Relationship (T)		19b Mailir	D. Address (Street and	ESSIE MAE		or Town State 2	Zin Code)
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Baltimore, Maryland 21215-0036			20a. Method of Disposition	20b, P	face of Dispo	osition (Name of matory or other place)	Date		Location · City or	
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	id in it		(Check only one) 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
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<u>ک</u>	To the Hospi within 24 hour To the Funer completely fill	Medica	29b. Signature and title of certifier A. M. 30. Name and address of person who c	and manner stated. completed cause of death (Iter	Mo :	Doug		_		
70	To the To the Committee of the Committee	nte	29b. Signature and title of certifier A. M. 30. Name and address of person who c	and manner stated.	Mo :	Doug		_		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CHARLES **EDWIN** JANUARY 20 2005 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOMEWOOD RETIREMENT CENTER WILLIAMSPORT WASHINGTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1⊠M 2□F Yrs. Director 577-22-1660 86 JULY 171918 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MARYLAND WASHINGTON WILLIAMSPORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 VIRGINIA AVENUE 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other treumatin. Elementary/Secondary (0-12) College (1-4or 5+) 12 GEAR CUTTER AIRCRAFT MANUFACTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Be CHARLES CLAYTON BARNES IRENE MAY LANTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALE BARNES/SON P.O. BOX 335, KEEDYSVILLE, MARYLAND 21765 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 Other (Specify) BOONSBORO CEMETERY 01/24/2005 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old national Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Pat1. Enter the disease of complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onser and Death 23a, Part1, Enter the disease Immediate Cause (Final disease or condition resulting in death) New Will Priysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part Il-Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No au (1 Yes 1 Tyes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magher of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) (C69 (aCTa eted cause of death (Item 23a) (Type, Print) 30. Name and address of perso 32. Registrar's Signatur 31. Date filed (Month. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:19 A 2005 Briscoe, Sr. January Sandy Minson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth

| Month, Days | Hours | Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 X M 2 □ F 7, 1933 Washington, DC Director 577-52-8193 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location il Hygiene. other than "naturel", or Iteme 23a or 28a-f ehow vent, tra Modical Examinar transt be notified at 1 Yes 2 □ No Maryland Capitol Heights Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 United States 209 Shady Glen Drive by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 MYes 2 ☐ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Maintenance Engineer 12 years 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Ethel Coleman William R. Briscoe Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other train 209 Shady Glen Dr. Capitol Heights, MD 20743 Reginald Briscoe - Brother Baltimore, 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1-E Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Maryland Vet. Cemetry Jan 28, 2005 Cheltenham, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service License 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, ochean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Know /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 🗆 No 9☐ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 4 Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3□ DOA this s after death.
I Director: After this
id in by the funeral d Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Iniun 1 Matural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title 041 completed cause of death (Item 23a) (Type, Print) PRIL LiAVE 3-4 bearing 9801 31. Date filed (Mc Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2 Date of Death 3. Time of Death JANUARY 15, 2005 CHARLES RAYMOND BENDER 1:15P.M. 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) St. Thomas Morre Nursing and Renabilitation Center Hyattsville Prince George's Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 2, 1948 If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 √ M 2 □ F 56 Yrs. 215-52-7950 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's College Park 1 TYPYes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9711 52nd Avenue 20740 United States 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give 1970–1973 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ᡚNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contracting Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Charles Bender Leatrice Joy Hagy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond C. Bender -father 9711 52nd Avenue College Park, Maryland 20740 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 1/26/2005 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 21. Signature of Faneral Service Licensee 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Hepatic Failure CINN losses Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medical **Examiner**

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Division of Vital Records, P.O. Box 68760,

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hours efter death

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yee 2 No

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Tes

1 ☐ Yes 2 ☐ No

26. I	Place of Death (0	Check only one)		
4	Nursing Home	5 Residence	6 □Other	(Specify)

25. Was case referred to medical				26. PI	ace of Death	(Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpetient	3□ DOA	Other: 4	Nursing Hon	ne 5 Residence	6 □Other (
27. Menner of Death	28a. Date of Injury	28b. Time of	28c.	Injury et	2	28d. Describe how inj	ury occurred

27. Menner of Death 1 Denatural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation (Month, Day Year) 6 Could not be determined

Injury

Work? 1 TYes 2 No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 20c. License number

Queensburg Rel Hystysville MD 2078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PALL 4203 (A ORE MI

2005

31. Date filed (Month, Day, JAN

32 Registrar's Signature

State Registrar

		_ 1	For State Registrar	tate of Maryla		rtment tificate			nd M		ene 3. No. 20	05	03112
	Physicia	an	Decedent's Name (First, Middle, Last)	BIANANI						2. Date of Death Month JAN	Day '	Year	3. Time of Death 2:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give stre NATIONAL NAVAL		NTER	4b. City, T		Location of THESD			4c. County o		
	Funeral Director			7. Age (In yrs	. /ast birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min. 3	8. Date of Birth (Month, Day, 1 / 0 9 / 2	(ear) 2005	9. Birthp Coun Bet	lace (State or Foreign try) nesda, MD
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County MD Montgome		ity, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 🏖 No
	with the	₫	10e. Street and Number 314 Prettyman 1	Drive #540)8	10f. Zip	Code 2085	50		10	g. Citizen of W		itry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28e-f show empty injury or other traumatic svent, I'm Medical Eracificar must be notified at once.	by Funeral		Was Decedent Ever in I Armed Forces? 1 [Yes 2 TNo If Yes, Give Year or Dates:	J.S. 13.	Was Decede f Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	in? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Race	- Americ , White,	
21215-0036	ithin 72 hour le. len "naturel" I Me Jical Er	Completed b	15. Decedent's Educal (Specify only highest grade of	ion	(Give	dent's Usual kind of worl DO NOT use	k done di	uring most	of workir	ng 1	6b. Kind of Bus		
1d 21	e filed wall Hygien other the	a l	17. Father's Name (First, Middle, Last)			none		18. Mothe	r's Name	(First, Middle, M	none aiden Sumame)	
Maryland	should by and Menta	ToB	Anthony Sims 19a. Informant's Name/Relationship (Type	Print)	19b. Mailir	ng Address	(Street a			hia Bia Route Number,		State, Zip	^{Cod} 20850
	and 2 s lealth ar m 27 ls her trau	-	Latrishia Bianan	i/Mother		Pret	ttym		riv	e #5408	B Rock	vil	le,Md
Baltimore,	Pages 1 nent of F nrt: If ite		20a. Method of Disposition 1	noval from State	cemetery, crer Gate o	natory`or ot	her place	n 1		-	oc. Location - 0 Silver		oring, Md
Balti	permit. Departm Importa eny inju		21. Signate of Funeral Service Licensee		9	241 (Colu	<u>ımbia</u>	a Bl		ver Sp	VIC rin	E, P.A. g, Md20910
	Pnysician		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.		er the mode				r respiratory arre	51,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse		2113 1	ICLA LI	.IORE					
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as a conse	equence of):								
8760,	ificate be executed g physician and as the burial-transit	Ical Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
.O. Box 68	death cert e attending id for use a	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pre					23d. Date Mon		ery Day Year
<u>а</u>	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contr	buting to death but not re	esulting in the u	nderlying ca	ause give	en in Part I.					ne cause of death?
Il Records,	The law ate has b page 2 si	Completed								24a. Was an autopsy perform 1X Yes 2	ed? di	nor to con	psy findings available mpletion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 XInpatient 2	☐ ER/Outpatier	nt 3 DO)A Othe			(Check only one		r (Specif	v)
on of		tion: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury Work	at c? Yes 2 🗆		28d. Describe ho			,,
Division	of or Attending after death. I Director: After d in by the fune	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special		reet, factory	, office			28f. Location (Str. City or Town,		or Aura	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Edition	rian: To the best of my k r: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred investigation,	at the tim, in my or	ne, date an pinion, dea	d place, a	and due to the ca	use(s) and mar te and place, a	nner as s nd due to	tated. o the cause(s)
	withi To t	Σ	29b. Signature and title in reprijer	8/3/		29c		-000		29	d. Date signed	(Month,	Day, Year)
•			30. Name and address of person who com		е т 23а) (Туре,	Print)		NAT		NAVAL I		CEN	TER
	Sta Regist	ate rar	KATVON ARFAA LT 31. Date filed (Month, Day, Year) JAN 19 200	MC USN 32. Hagistrar's Sig	nature A	porte	9	וויינט	נעטעני.	<u> 200</u>	55 5000		
Br	riegist	, ell %	JAN 10 200	NA SELVINO	- /								

Mease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:00 PM James R. Brooks Jr. 2005 Janvary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Baltimore Stella Maris If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 157M 2 7 F 83 Director Nov. 6 1921 Maryland 212-16-5167 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State or itams 23a or 28a-f show 1 XYes 2 No rector arvland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 21403 126 death v 930 Bay Forest Ant. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 17 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status item 27 is marked other than "natural", or Itam other traumatic event, It's Medical Examinat Black, White, etc. filed within 72 hours after 1 Yes 2 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ If Yes, Give Year or Dates: W.W.II 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12th Ω Forklift Operator Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t and 2 should be fill Health and Mental H tem 27 is marked oth Be James R. Brooks Sr. Alice Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cameron Grove Blvd. Unit 207
Date | 20c. Location - City or Town, State of Health Janice Staten (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages T Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. = 5 Maryland Beteran 1/21/05 Crownsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, F 821 West St. Annapolis, Md. Shock, or heart failure. List only one cause on each line. P.A. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician polon CANCE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HD854 14/200 -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCIVIL Kiseberg strar's Signature 31. Date filed (Month, Day, Year) 32. Re State 2005

DHMH 17 Rev 1/2001

Registrar

			r icase i	State of Maryland	d / Depa	artment of He	ealth ar	nd Ment	al Hygie	ne _{o o}	C P.		
		1	For State Registrar			tificate of D				No.4	05	031	14
		_	1. Decedent's Name (First, Middle, Last)						ate of Death onth	Day	Year	3. Time of I	
	Physicia /Medic	al .		<u>Marie Bathon</u>					nuary	24	2005	0300	A ^M
	Examin	er	4a. Fecility Name (If not institution, give	treet and number)		4b. City, Town, or	Location of	Death		4c. County of Death Cecil			
			385 River Road 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	Elkton If Under 1 Year	If Under 2		te of Birth		9. Birthpla	ace (State or	Foreign
	Funeral Director			M 2□ X F 45	Yrs.	Months Days	Hours		fonth, Day, Ye ril 14,		Mary		
	p ,		Usual Residence of Decedent 10a, State 10b, County	10c City	. Town or Lo	cation					10	d. Inside City	y Limits
	shov	ō			lkton							1 🗆 Yes	2 💢 No
	the h	Director	Maryland Cecil 10e. Street and Number	<u> </u>	IKLUII_	10f. Zip Code			10g.	Citizen of	What Count	ry?	
	h with	ai Di	385 River Road			21921				Unite	d Sta	tes	
	ems 2	Funerai		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Y Puerto Rican	es or No- , etc.)		ce - America ick, White, e		
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2 🛣 No	Specify:			Speci	‰ Whi	to	
8	thour	ed b	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	tion	of working	161	b. Kind of E	Business/Ind		
215	hin 72 an "na Me ali	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,	uning most	di working		_			
7	ed wit ygiene yer tha	Completed		4	Pro	ject Mana		's Name <i>(Fir</i> s	t Middle Ma	Rese			
and	ntal H	Be	17. Father's Name (First, Middle, Last)	anti				emary 1		oon cama			
Maryland 21215-0036	thould id Mer mark matic	ဥ	Richard J. Pinamo		19b. Maili	ng Address (Street a				ity or Town	, State, Zip	Code)	
Ma	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28s-f show other transmatic event, the Medical Evantual must be recitived at		Lawrence C. Bathon	, Jr./Husband	385 I	River Road	1, Elk	cton, M	larylan	id 219	921		
ore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	20b. P	lace of Dispo	osition (Name of matory or other place ce Concept	Jan Ja	anuary	2/,		- City or To		
ij	Pag ment ant: b		`4 ☐Donation 5 ☐ Other (Specify)	Cem	etery		20	005			Hill,	Mary]	Land
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Sign ture of Funeral Service Licens	00	H.	Name and Address icks Home 03 W. Sto	for	Funera	Ls, P.A	1.	Maru 1 a	nd 210	221
			23a. Part1. Enter the disease, or comp	ications that caused the death							lai yia	Approximate Interval Betv	•
	Physician		shock, or heart failure. List only o Immediate Cause (Final	4 ()	o chas	no Mul	thec	^ 5				Onset and D	Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	11/400	J. C. Car						
	Examiner		Sequentially list conditions,	b	uence of):								
X	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uerice or,								
Li	eath certificate be executed attending physician and for use as the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
,092	ysicia	ical	(d									
68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE:	20. 16						004.0	-16		
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)					ate of delive lonth		'ear
0	at the de by the a tached t	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	iodiii ot								
Δ.	es that igned b	by Pr	Part II. Other significant conditions co		ulting in the u	underlying cause give	en in Part I.	:	23e. Did toba				
Records,	w require been sig should b		Cushings Sy	ndime					1 🗌 Yes	3√ No	3 Prob	ably 4 □U	Inknown
ecc	taw re as be	Completed							24a. Was an autopsy performe		. Were autoperior to condeath?	psy findings a apletion of ca	available ause of
E B		Con							I Yes 2	No	1 Yes	2 🗌 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	or	of Death (Ch rsing Home	5 Residen	m 6∏0	ther (Specifi	v)	
of		7: To	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time				Describe how			,	
ion		atlor	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2□						
Division	To tha Hospital or Attendi within 24 hours atter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, si	treet, factory, office		28f. t	ocation (Stre City or Town,	et and Nun State)	nber or Rura	I Route Num	ber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		70 000	vsician: To the best of my kno		th account of the time	no doto an	d place, and o	tue to the cau	se(s) and r	nanner as si	rated	
	Hosp 24 hol Fune stely fi	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ation and/or i	nvestigation, in my o	pinion, deal	th occurred at	the time, date	e and place	e, and due to	the cause(s)
	ro tha	Me	29b. Signature and title of certifier			29c. Licens	e number		290	. Date sign	ned (Month,	Day, Year)	
			1	\sim		Da	05632	27		1/26	105		
	"		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type	, Print)	Cor	. `	2110-				
			31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature ST	2 JE 2	FIKAGY	m)	2192	1			
	St Regist	ate trar	FFB 0.2.20	32. Registrar's Sign	Is A	aced 1							
DI	HMH 17 Rev 1/3		FFB V & ZU		19								

ORIGINAL

			For State Registrar	State of M	aryland /		artment rtificate				Reg.	ne 005	03115
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, La Lottie 4a. Fecility Name (If not institution, give Washington Cov	Virgin:		Ch		own, or	Location o	f Death	Date of Death Month MULA P	Day Year 2/2003 4c. County of Dea Washi	S 0945 M
	Funeral Director		Social Security Number 6. 8		ge (In yrs. last bi	rthday) Yrs.	If Under 1		If Under 2 Hours		Date of Birth Month, Day, Ye	9. Bit	thplace (State or Foreign ounty) Maryland
	e Maryland la-f show lifted at	ctor	10a. State 10b. County	ington	10c. City, Tow		rstow	۷n					10d. Inside City Limits 1X☐ Yes 2☐ No
	ath with the 23s or 28	Funeral Director	10e. Street and Number 750 Dual High				10f. Zip (217				U.S.	Α.
9800	72 hours after death with the Maryland "netural", or Itema 23a or 28a-f show idical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 1 If Yes, Give Year or Dates:	?		Was Decede If Yes, specif 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Whi	
21215-0036	d within jiene. r than	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) Coltege (1-4or		Dece (Give life. S a	dent's Usual kind of work DO NOT use 1es (Occupa k done di e retired) Cler	tion uring most	of working		epartment	·
Maryland	bed la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Las		Fie				Sa	erah	st, Middle, Mai Ja	ne	Bailey
	ulth ar 127 Is 1 trau		Jane Ellen Souc									ity or Town, State, COWN, Md.	
ore,			20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 0	Removal from State	20b. Place of cemete) [Date		. Location - City or	
Baltimore,	permit. Page Department of Importent: If any injury or once.		'4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		nose		1 Ceme			01-25- an Fur		ome, Inc.	, Maryland
	205 g g		23a. Part1. Enter the disease, or con shock, or heart failure. List only	Drady pplications that ause	d the death. Do	not ent	0 East er the mode	t An	tieta , such as c	m_Stre	et, Hac	gerstown,	Md . 21740 Approximate Interval Between
	Pnysician	1	Immediate Cause (Finat disease or condition resulting in death)	a. Atheros	eleroti	v	Carde	4007	rseul		Wase		Onset and Death
	/Medical Examiner			Due to (or as	a consequence	of):							
.00	death certificate be executed death certificate be ettending physician and by for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence								
09289	tificate b g physic as the b	ledicai		d									
.O. Box	the death certific y the ettending pi ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pre Other (spe					23d. Date of de Month	livery Day Year
<u>α</u>	law requires that the dias been signed by the	by	Part II. Other significant conditions	contributing to death I	out not resulting	in the u	nderlying ca	use give	n in Part I.		23e. Did tobac		o the cause of death?
al Records,	The tar ate has page 2	Completed	OS Management to medical								24a. Was an autopsy performed 1 ☐ Yes 2 ♥	prior to death?	utopsy findings available completion of cause of
of Vital	nysici iis ce direc	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		utpatier	nt 3 DOA	Otho			<i>seck only</i> o <i>ne)</i> 5 ☐ Residence	e 6 □Other (Spe	ocify)
	ing After une	ation:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, Da	ury 28b. ay Yeer)	Time o Injury	f 28 M	c. Injury Work 1 Y	at ? 'es 2 □ N		Describe how i	njury occurred	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place of III	jury - At home, f tc. (Specify)	arm, str	reet, factory,	office			Location (Stree City or Town, S		ural Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dire completely filled in the Funeral Direction of the Funeral Di	edicai C	29a. Certifier 1 Certifying P (Check only one) Check only 2 Medical Exa	nysician: To the best miner: On the basis of and manner s	of examination as	e, deat nd/or in	h occurred a vestigation, i	it the time in my opi	e, date and inion, deat	d place, and o	due to the caus t the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the To the Comp	X	29b. Signature and title of certifier May	98	uaf	7.	29c.	License	number 283(05		Date signed (Mont	
0	H2		30. Name and address of person who	completed cause of 3 (a & Y	death (Item (26a)	Туре,	Print)	tag	. Md	21	740		
	Sta Registr		31. Date filed (Month DAY Year)	11111	rar's Signature	jaj	nede	- /					

			1 - For Amend Item 5	State of Maryla per informa	nd / Dep		of Health and -05 tas of Death	•		005	03116
			Decedent's Name (First, Middle, Last)					2. Date of De	ath ·		3. Time of Death
	Physici /Medio Examir	al	Liliana G. Chiappin 4a. Facility Name (If not institution, give s			4b. City, To	wn, or Location of Dea	Janua:		2005	1:40 A M
	Lxuiiii	Ŭ.	Villa Rosa Nursing	2 Home		Mitc	hellville		Prin	nce Geo	rge's
	Funeral Director		5. Social Security Number 6. Sex		s. last birthday Yrs.		Year If Under 24 Hi Days Hours Min		h Y, Year) +, 193	9. Birth Cou Ita	place (State or Foreign ntry) Ly
	land ow		10a. State 10b. County	10c. (City, Town or L	ocation					10d. Inside City Limits
	Mary Fish	ξ	Maryland Prince Geo	orge's Mi	tchelly	ville					1□Yes 2□No
	th the	lrec	10e. Street and Number			10f. Zip C	ode		10g. Citizer	of What Cou	ntry?
	238 c	ral	3800 Lottsford Vis	sta Rd.			20721		Ü	JSA	
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or tiems 23a or 28a-1 show avant, the Medical Examinar must be routlied at	by Funeral Director	11. Marital Status The Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	U.S. 13.	Was Deceder If Yes, specify	at of Hispanic Origin? (Cuban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		Race - Ameri Black, White pecify: Ca	
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Giv	DO NOT use	done during most of w	rorking		of Business/Ir	ndustry
2	filed v Hygie othar t		17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	16	acher	18 Mother's N	ame (First, Middle,		ation	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic avent, Its M.	To Be		4						,	
ary	should ind Men s marka umatic	۲	Pietro Chiappinell 19a. Informant's Name/Relationship (Ty) Dominic Santarpia	oe, Print) Brothor—	19b. Mail	ling Address (5	Maria A	ntonia Fa Rural Route Numbe	LL cone or, City or To	own, State, Zi	o Code)
	1 and 2 Health a tam 27 Is		Dominic Santarpia	- in-law	948	Medira	Dr. Lady	Lake, FL	32159	9	
Baltimore,			20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R	emoval from State		matory or other	er place)	Date		ion - City or T	
ij	permit. Pages Department of Important: If it any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	G	ate of			18/2005			
Bal	permit. Pages Department of Important: If I any inlury or once.		21. Signatur of Funeral Service License	UL	1	1800 N		re Ave. S	ilver		ноте g, MD 20904
	Pnysician	i	23a. Part1. Enter the disease, or complished, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the delete cause on each line. Pneumon:		nter the mode	of dying, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death Days
	/Medical Examiner		resulting in death)	Due to (or as a cons Metasta	equence of): tic Bre	ast Ca	ncer				Yrs.
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons							
_	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a cons	equence of):					1	
68760,	ficate be (physicier s the buri			l							
.O. Box (Attending Physician: The law requires that the death certificate be executed refeath. sctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic preg □ Other <i>(spec</i>			23d	. Date of deliv Month	ery Day Year
٩.	res that i		Part II. Other significant conditions con	tributing to death but not r	esulting in the	underlying cau	se given in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
rds	w requires been sign should be	ed by						101	′es 2 🗆 N	lo 3 🗆 Prol	pably 4 Munknown
Il Records,	ysician: The law requiscertificate has been director, page 2 shoul	Completed						24a. Was autop perio 1 Yes		prior to co death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				eath (Check only o			
of	Phys r this ral dir	. To	1 ☐ Yes 2 🛣 No	1 ∐ Inpatient 2			Other: 4X Nursing	Home 5 ☐ Resid			(y)
on	th. : After s funer	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	. Injury at Work? 1 ☐ Yes 2 ☐ No	200, 2000, 201	iow injury o	0001100	
Division	al or Attendi safter death. I Diractor: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, s cify)	treet, factory, o	ffice	28f. Location (5 City or Tou		lumber or Run	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at nvestigation, in	the time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and pla	d manner as s ace, and due t	stated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	الم .		29c. l	icense number		29d. Date s	igned (Month,	Day, Year)
	(0		MI	The state of the s	Mos		D32261		Janu	ary 17	, 2005
	4		30. Name and ad ress of person w io co								
			Richard Feldman, 31. Date filed (Month, Day, Year)	M.D. 9500 A	nnapoli	s Rd.	Lanham, MD	20706			
	Sta Regist		JAN 19 200		J. A						

			1 – For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H			ene . 2 0 (15	03117
			Decedent's Name (First, Middle, La	ist)				2. Date of Death	1	, 0	3. Time of Death
	Physicia /Medic		Dorothy G.	Coulson				January	14,20	05	6:30P M
	Examin		4a. Facility Name (If not institution, give		er)		Location of Death		4c. Count		
			Suburban Hospit 5. Social Security Number 6.5		Ann the une to at hinth day	Bethes If Under 1 Year	da If Under 24 Hrs.	8. Date of Birth	Mont	gomer	
	Funeral Director		577-22-6437	1 □ M 2 1 F	Age (In yrs. last birthday, 85 Yrs.	Months Days	Hours Min.	Nov. 19,	Year) 1 919	West	place (State or Foreign ntry) Virginia
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside City Limits
	Maryll f eho	ō	Md. Montgom	o r v	Silver S	nring					1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number	CIJ	DIIVEI D	10f. Zip Code		10	g. Citizen of	What Cou	ntry?
	th with		15107 Interlac	hen Dr.	#814	20906			U.S.A	•	
	- dea	Funeral	11. Marital Status	12. Was Decede Armed Force		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian, etc.
36	s afte	by Fu	1 Never Married 2 Married 3 ₩ Widowed 4 Divorced	1 ☐ Yes 2! If Yes, Give Year or Date		1 ☐ Yes 2 🕱 No	Specify:		1	'n Whi	
Ş	thour stural	edt	15. Decedent's E		16a, Dece	dent's Usual Occupa	ation	1	6b. Kind of 8		
215	hin 72 9. M. Ind	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	(Give	kind of work done of DO NOT use retired	during most of work)	king			
213	od with	Com	Elementary, coolings, (c. 12)	2		Secretary		U	.S. A:	irfor	ce
P	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las.	")				e (First, Middle, M			
ry B	d Men narke	2	Herbert Grin 19a. Informant's Name/Relationship		10h Mail	ing Address (Street a	Audr		nknow		- Code
Maryland 21215-0036	d 2 sl th and t7 le r traur		Rebecca A. Harris			Sentine1					
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygleine. Important: If Item 27 is marked other then "natural", or Iteme 23s or 28e-f ehow any injury or other traumatic event, Ite Modical Examinar must be notified at once.		20a. Method of Disposition	(Daugnee	20b. Place of Disp				Oc. Location		
9	G = = D		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Con		ate	Cremator	1	18,2005 R	iverda	ale.	Md.
Baltimore,	partm porta y inju		21. Signature of Funeral Service Lice	nsee)		hambersdor		The second second second			
ω_	89 5 8 8		Thomas S.	Chamb		801 Cleve					
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	oplications that cau one cause on eac	sed the death. Do not en h line.	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition	a. COPD							Onset and Death
	/Medical Examiner	П	resulting in death)	Due to (or	as a consequence of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):					-	
10	ficate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events								
2005 7 60,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or	as a consequence of):						
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7 0	ertifica ling pl	Med	IF FEMALE:	00. 11							
₹ ₹ EBox	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of deliv onth	ery Day Year
0 2 40	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		Other (specify)					
550	The law requires that the death certificate has been signed by the attending loage 2 should be detached for use as		Part II. Other significant conditions	contributing to deal	th but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to	the cause of death?
امد ج Records,	w requires been sign should be	ed by	CHF					1 ☐ Ye	s 2 No	3 🗆 Pro	bably 4 Dunknown
o o	aw requ	Completed						24a. Was ar		Were aut	opsy findings available
∑ %	The I	E O						autopsy perform	red?	death?	ompletion of cause of 2 No
Dorothy on of Vital F	Physician: The law this certificete has be ral director, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one			
of V	hyeic this ca	ို	1 ☐ Yes 2 🛣 No	Hospital: 1 Inp			4 Nursing H	ome 5 Reside			fy)
Do un	aling Phyon. I. After this funeral di	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Day Year) 28b. Time Injury	Worl	yat k? Yes 2 □ No	28d. Describe ho	w injury occu	rred	
Son, De	death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	h	f Injury - At home, farm, s		163 2 1110	28f. Location (Str	eet and Num	ber or Rur	al Route Number.
Sci	efter Olive d in b	ertii	4 Homicide	building	f Injury - At home, farm, s i, etc. (Specify)			City or Town	, State)		
Coulson) Divisi	ospita hours unerel		29a. Certifier 1 Certifying F	hysician: To the b	est of my knowledge, dea is of examination and/or i	th occurred at the tin	ne, date and place,	, and due to the ca	use(s) and n	nanner as :	stated.
S	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	and manne	r stated.						
	To To	Σ	29b. Signature and title of certifier	010	31.0	29c. Licensi		29	d. Date sign	ea (Month,	Day, Year)
	13		1///	1/an	r\ ()		2347	J	anuar	y 14,	2005
			30. Name and address of person who Marjorie Dann		of death (Item 23a) (Type 8600 Old Ge		Rd Roth	hM chac	2071	R	
	St	ate	31. Date filed (Month, Day, Year)	32 Reg	gistrar's Signature	OT PECOMIT	was nerile	coua, III.	20/1		
	Regist		IAN 192	nns	H. A	SHEL					

			For 1 _ State	State o	f Marylan	•				fental Hy	gien	200	5 00	110
			1 Registrar			Cei	TITICAT	e of Deat	ın	2. Date of De	Reg. No	<u>, </u>	0 00	110
	Physicia /Medic		Decedent's Name (First, Middle,	•	REMIAH :	LAVERN	CLIN	GAN		Month Januar		, 2005	3. Time	A.M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or Location	on of Death		40	. County of De	eath	
		ш	Northampton Man	or Nursi	ng Home		Fre	ederick				Freder	ick	
	Funeral Director		5. Social Security Number 218–24–9928	5. Sex 1 GM 2 □ F	7. Age (In yrs. 7		If Under Months	Days Hour	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da June 14	th y, Year	9. E 929 Ma	Birthplece (State Country) aryland	or Foreign
,			Usual Residence of Decedent										7	
	how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside (
2	a-fa	cto	Maryland Frede	rick	Thu	rmont							1 🗆 Ye	s 2 No
4	or 28	Director	10e. Street and Number				10f. Zip				10g. C	itizen of Whal	Country?	
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2	2 should be line within 7 chous after beath with the maryanto that Model Hygiene. Is marked other than "natural", or liems 23a or 28a-f ahow aumstic event, the Model Examiner must be modified at	Funeral	11. Marital Status 1 ☐ Never Married 2 🛣 Marrie	Armed Fo	2 No		Was Deced f Yes, spec	ent of Hispanic of Cuban, Mexi ⊇XX No Speci	can, Puerto	ecify Yes or No Rican, etc.)	>-	14. Race - Ar Black, W Specify:	merican Indian, hite, etc.	
3	Era!	d by	3 Widowed 4 Divorced	Year or D	Dates: 48-5	<u> </u>			, .				Vhite	
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١.	han .	ם	Elementary/Secondary (0-12)	College (1-4or 5+)						MD	C	7 ! - 1	A 1 .
1	tygie her t		8 17. Father's Name (First, Middle, Li	acti	-	11	ruck I	Oriver	other's Nam	e (First, Middle			lighway	Admin.
	tal H	Be	Jeremiah B. Cli						y Weis		, Maiuei	7 Surname)		
× 1	1 Mer narke	٩				105 11-11-					0'h-	T C1-A-	T- 0-4-1	
	o z should th and Mer 7 is marks traumatic		19a Informant's Name/Relationshi Rita Clingan (W				•	(Street and Nun						
υ,	Health Health Health ther to		20a. Method of Disposition	116)	20b. F	Place of Dispo		anklinvi	+	Date I			or Town, State	
5	reges nent of h nnt: If ite		1 Burial 2 ☐ Cremation :		State	cemetery, cren	natory or o	ther place)	1					
	rtant rtant njury		' 4 □ Donation 5 □ Other (Special Service Li		Res			Garden		2/05	Fre	derick.	Maryla	ınd
Da	permit. Peges 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		Tole to	5	last	RC	BERT 5 FA	d Address of Fa E. DAIL T MAIN	LEY &	THIIDMON	ו ידו	L HOMES	S, P.A.	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that only one cause of	aused the deat	h. Do not ent	er the mod	e of dying, such	as cardiac	or respiratory a	rrest,		Approxima Interval Be	tween
ρ	hysician		Immediate Cause (Final disease or condition		Cenyu	27 re	hea	ie la	iline				Onset and	Death
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9	ing pt	Med	IF FEMALE:		32,500, 32					-				
2	eath cernic attending pl	an/l	23b. Was decedent pregnant in the past 12 months?		tcome of pregna birth 2 Feta		Ectopic pr	egnancy				23d. Date of d Month	lelivery Day	Year
	the at	Physician/Me	1 Yes 2 No	4☐ Pregr 9☐ Unkn	nant at time of d	leath 5	Other (sp	ecify)				WOLIGH	Day	i bai
	d by t	Phy				Main - I - Ab -				22a Did	-			double 2
ń	w requires that the de been signed by the signonid be detached	þ	Part II. Other significant condition	al Van	Cellar I	aling in the ur	nderlying c	ause given in Pa	irt i.		Yes 2		to the cause of Probably 4 2	Unknown
5	pinor	ted	- / / / / / / / / / / / / / / / / / / /	al van						'	165 2	- LNO 3	Probably 4 E	JOHANOWH
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ב ו	ate h	ĕ								perfo 1 ☐ Yes	rmed?	death 1 □ Y	? es 2□No	
2	artific ctor,	Be (25. Was case referred to medical examiner?					1	ace of Deat	h (Check only	one)			
5 8	his ca	P	1 ☐ Yes 2 🗹 No			ER/Outpatien			Nursing Ho	me 5 🗌 Resi			pecify)	
	of the rection of the	 	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury		Bc. Injury at Work?		28d. Describe	how inju	iry occurred		
2	eath.	catl	2 Accident investiga	nt he			М	1 Tes 2	□No					
2	irect irect	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place	e of Injury - At h ling, etc. <i>(Specil</i>	ome, farm, stri fy)	eet, factory	, office		28f. Location (City or To	Street a. wn, Stat	nd Number or e)	Rural Route Nui	nber,
ָ ב	rel D													
-	To the hospitel or Attending Priystoan: The law requires that his death certificate be executed within 24 better certificate that been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the b and man	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	n occurred vestigation,	at the time, date in my opinion, o	and place, death occur	and due to the red at the time,	cause(s date an) and manner d place, and d	as stated. ue to the cause	s)
;	o the	Med	29b. Signature and title of certifier				290	. License numbe	er		29d. Da	ite signed (Mo	nth, Day, Year)	
١	- 3 ⊢ ŏ) d	-pr 1	nD.		1	ME	415	2/2	01	-19	-700	5
	X		30. Name and address of person w	to completed one	se of death (Iter	n 23a) (Tune	Print)		14	20		1-1	~~~	
1	ス		Syed Haque, MD	700 Mont				derick,	Mary	land 21	701			
	Sta	ite	31. Date filed (Month, Day, Year)	32 F	egistrar's Signa		A.C.							
	Registr		JAN 2 (2005		S. A	1934K	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** 18 4:20 PM January Lucylle Marie Chesemore /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 10 9. Birthplace (State or Foreign Country) Nebraska 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🗶 F 19, 410-76-7481 June 93 1911 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mantal Hygiene.
ans. If items 72 Is marked other than "natural, or Items 23e or 28a-f ehow ans. If item 27 is marked other than "natural, or flees haven it is Mades Examines must be notified. 1 Yes 2 No Directo Paris Tennessee Henry 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 38242 115 Green Acres Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Richter John P. Brick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16024 Bonniebank Terrace, Darnestown, Maryland, 20874 Ronald G. Chesemore/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 01/22/2005 Paris, Tennessee Memorial Cemetery ` 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 106 East Church Street Millian Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERY DISEASE CORONARY Physician /Medical Due to (or as a consequence of) Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 si 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 2 1 Tes this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Date of Injury Certification: (Month, Day Year) 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death Diractor: /

Baltimore, Maryland 21215-0036

thin 24 hours after the Funeral Dira mpletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 DO057124 1119105 In uns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD, 13219 Executive Park Terrace, Germantown, Maryland, 20874

32. Registrar's Signature State Registrar

		-	State of Maryland / Department of State of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department / D		
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
	Physicia		Ernestine Carter	Januar	Cy 14 2005 6:25 p
	/Medic Examin			wn, or Location of Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months 0	Days Hours Min. (Month, Day	(, Yeer) Country)
	Director	-	192-16-2416	July 1	2 1921 Pa.
	show		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mai	ig 1	Maryland Anne Arundel Annapolis		MONYes 2 No
	or 28	Director	10e. Street and Number 10f. Zip C	ode 1	log. Citizen of What Country?
	s 23a	rai	1008 Monroe Street. 214 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceder	03 It of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any finity or other traumatic event, if a M. died Exchiner must be neitlised at once.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 □ Yes XI	Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc. Specify: Black
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Baltimore,	permit. Pages 1 Department of H Important: If ital any Injury or oth		20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Description	orplace)	Annarolis, Md.
3alt	permit. Departi Import any Inj once.		21. Signature of Funeral Service Licensee 22. Name and	Address of Facility	1.00 NO NAME (SECOND IN PROPERTY)
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Division	Attending r death. actor: After	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, or	office 28f. Location (S	treet and Number or Rural Route Number,
Ö	s afte	Cert	4 Homicide building, etc. (Specify)	City or Tow	n, State)
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.		
	Tot Tot	Σ	29b. Signature and title of tentier 29c. I	was under 236 bare Ush	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	is Dure Clashie	M 2 (619
×2.	Sta _ Regist		31. Date filed (Month, Day Year) AN 1 9 2005 Registrar's Signature		~ /
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Physiciar /Medica Examine

Funeral Director

	for State	State of Ma	_			nd Mental Hy	giene	0 67	0010	1
	Registrar			Certificate c	t Death		Reg. No. U	JO	0316	<u>. l</u>
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al	Domenick Chiddo 4a. Fecility Name (If not institution, g	in atreat and number)		Ab City Tour	, or Location of	January	4c. County	2005	12:10 _I	P ₽
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cto	Maryland Anne A	rundel	Annapol	· · - · - · · · · · · · · ·						1110
吉	10e. Street and Number			10f. Zip Cod			10g. Citizen of V		,	
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Š	11. Marital Status 1 □ Never Married 2 ★ Married	Armed Forces?		If Yes, specify C	uban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		ck, White, e		
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2	Francisco Chidd					rgh e rita S				
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	20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3	☐Removal from State	cemetery,	crematory or other p			20c. Location -	•		
	'4 □Donation 5 □Other (Spec		Gate o			n. 19, 200		-		_
	21. Signature of Funeral Service Lic	7		22. Name and Ad	ress of Facility	John M. T	aylor Fu	nerai	Home,	Inc
	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lir	the death. Do not not not not not not not not not no	ailure	ying, such as c	ucester St ardiac or respiratory a	rrest,	í	Approximate interval Between Onset and Death	1
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y P	Part II. Other significant conditions	contributing to death be	ut not resulting in t	he underlying cause	given in Part I.	23e. Did t	obacco use contr	ibute to the	cause of death?	?
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	To seah Fr	rend 116	Defens	c Hwy	Anna	Iclis, wel.	21401			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Modifin, Day, Year)

JAN 1 8 2005

32. Resistrar's Signature

Huy Annapolis,

AG		1 - Stete Unpend Item 2	State of Marylar 23a,27,28a-f	nd/Depa per me <i>Cer</i>	rtment of 5 G840 2-1 tificate of	lealth and 0-05 tas Death	Mental Hygi	ene 200	15 03122	
Physicia	n	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death	
/Medica			eroy	Ca	innon			24, 2005		
Examine	er	4a. Facility Name (If not institution, give s			4b. City, Town, o		th	4c. County of E		
Funeral		Port of Salisbury 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hr	8. Date of Birth			
Director	-	219-60-2093 X	M 2□F	52 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, July 3,	1952	Birthplace (State or Foreign Country) Salisbury, MD	
pug .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Lo	ration				10d. Inside City Limits	
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the t	Director	10e. Street and Number	Sa.	lisbury	10f. Zip Code		10	g. Citizen of What		
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be filled within 72 hours after death with the Maryland lal Hygiene. d other then "naturel", or items 23s or 28s-f show event, the Medical Everth at mast be rivillated at	ed	15. Decedent's Educ	Year or Dates:	16a Deced	ent's Usual Occup	ation	1	6b. Kind of Busine		
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should be ind Menta marked umatic ev	၉	Emmett W.		Cannon		Mary	Franc		Liming	
2 2 2 2		19a. Informant's Name/Relationship (Ty) Tommy W. Cannon-Sor		1			ural Route Number,			
C = W P		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other place	Tall Stre		Oury, Ma Oc. Location - City	ryland 21804	
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permit. Page Department of Important: If any injury or otice.		2. Signature of Funeral Service License	Cer	netery	Name and Addres	ss of Facility	ary 31, 2005	Show Hill	l Marylard l Association vland 21804	
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To the within To the compl	Ž	29b. Signature and title of certifier	/		29c. License	e number	290	1. Date signed (Mo	onth, Day, Year)	
		Yande Frouth	Ell. MID		0	.C.M.E.	Ja	nuary 25	, 2005	
		30. Name and address of person who co		n 23a) (Type, F	Print)					
-01-1		31. Date filed (Month, Day, Year)	hail, M.D. 32. Registrar's Signa	iture	111 Penn	Street,	Baltimor	e, Maryl	and 21201	
Stat Registra		FEB 0 3 2005	Book At		,					

State of Maryland / Department of Health and Mental Hygiene 0 05

	Physici /Media Examir	¢a
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If least 23s or 28s-1 sh Important: If least 23s or 28s-1 sh any injury or other traumatic event, the Medical Examiner must be nutified once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit law requires that the death certificate be executed P.0. the Š certificate has Vital this After To the Hospital or Attending death. Director: e Funeral Direct

1 16 05

CUTLER

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 16, 2005 7:45P LEAH 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL BETHESDA | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | DEC • 4 , 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2□F PENNSYLVANIA Yrs. 161-26-6508 71 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1√ Yes 2 No Director BETHESDA MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5225 POOKS HILL ROAD, APT. 501 20814 UNITED STATES OF AMERICA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GUIDANCE COUNSELOR **EDUCATION** 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELI CUTLER AGNES COHEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 397 AUTUMN HILL DRIVE OXFORD, PA JAMES HARRISON - COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) WORKMANS' CIRCLE CEM. 01/21/05 SHAVERTOWN, PA 21. Signature of Funeral Service License DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused #9 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Immediate Cause (Final MASSIVE CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown DIABETES MELLITUS, HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 💢 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62347 JANUARY 17, 2005 30. Name and addre to 1 person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

M. DANNIS 31. Date filed (Month, Day, Year)

2 0 2005

within 2.

32. gistrar's Signature

100000

8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20718

Toi-Lynn Claggett 05-00306 RPD

Plea

ıse	Type or Print in Black Indelible ink.	Ensure	AII	Copies	Are	Legib
	State of Maryland / Department of H	ealth and	M	ental Hyd	iene	

For	State of Maryland / Department of Health and Men	tal Hygie
= State	Certificate of Death	

State Registrar			Certificate of Death	Re	g. No.	105	03	12	L
1. Decedent's Name (Fir	st, Middle, Last)			2. Date of Death			3. Time o	of Dea	th
TOI	LYNN	CLAGGETT		January	12,	2005	2352	P	N
4a. Facility Name (If not	institution, give stre	eet and number)	4b. City, Town, or Location of Dea	th	4c. Cou	unty of Death			

/Medical Examiner

Physician

5. Social Security Number **Funeral** 214-23-3919 Director

Direct

Completed by Funeral

Be

Usual Residence of Decedent 10a State 10b. County

University Hospital

7. Age (In yrs. last birthday) 1 □ M 2€ F Yrs. 16

Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 24,1988

 Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

10c. City. Town or Location MD Montgomery Germantown

XXYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country?

10e. Street and Number 12700 Found Stone Rd. #302

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: XXNever Married 2 Married

20876 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) llth

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

School

U.S.A.

17. Father's Name (First, Middle, Last)

3 Widowed 4 Divorced

Ron S. Claggett

18. Mother's Name (First, Middle, Maiden Sumame) Tamara H. Claiborne

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13112 Prices Distillery Rd., Clarksburg, MD

Date

Ron Claggett (Father) 20a. Method of Disposition 1 ☑ Byria 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

Parklawn Mem. Park 1/21/05

Rockville, MD

*4 ponation 5 Other (Specify)

21. Signature of Funeral Service Ligensee

22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

the burial-transit

attending physician and

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The law requires that the death certificate be executed

Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

funeral

filled in by

Director:

24 hours a

within 2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 27s any injury or other traums**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

mes Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 **2** Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No 27. Manner of Death

Hospital: 1X Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending 1-12-05 investigation 6 Could not be determined

28b. Time of Injury 12:10P

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

De to and parsenge rejected

Literatury exercises and Parish Numbers. 281. Location Street and Number or Rural Route Numbers City or Town, State) J. F. Cerson Next 1 Pearls at Jefflerson P. Le, Jefflerson M. I.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

29b. Signature and title of certified

1 Natural

2 Accident

4 | Homicide

3 Suicide

29c. License number O.C.M.E.

road

Defining Physician: 10 the desiron by knowledge, death occurred at the time, date and place, and date on the deade(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland 21201

January 13, 2005

Registrar

31. Date filed (Month, Day, Year) JAN 2 0 2005 32 Registrar's Signature

		1 - For State Registrar				Health and		_	03125
Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medi Examir	cal	Elizabeth Th		talina	4b. City, Town	, or Location of De	Junuary	16, 2005 4c. County of Death	02:20 AM
		Sunbradge -Nurs	ing Home		Elkt	on, MD		Cecil	. *. *1
Funeral Director		Sunbridge Nurs 5. Social Security Number 6. Se 221-12-9950 Usual Residence of Decedent	x 7. Æge (i]M 27∏ F	In yrs. last birthday) 82 Yrs.		r If Under 24 H		ear) 9. Birth	nplace (State or Foreign untry)
and *		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	cation		-		10d. Inside City Limits
Maryll f sho	ō	MD Cecil		Earlevi		aruland			1 ☐ Yes 2 🎇 No
the 1	rect	10e. Street and Number		Larrevi	10f. Zip Code		100	. Citizen of What Co	
3a or	<u> </u>	1199 Crystal	Beach Roa	ьд	219			USA	,
deatl	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?				(Specify Yes or No- erto Rican, etc.)	14. Race - Amer	
15-0036 72 hours after death with the Maryland "natural", or ftema 23s or 28s-f show salical Examinations by multified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	1 ☐ Yes 2 ☐ X N		ano nican, etc.)	Black, White	
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of w	orking 16	b. Kind of Business/I	ndustry
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yla nouid narke	၉	Richard R. Co				The second secon	ence O'Co		
Mar 12 sho h and 7 is m		19a. Informant's Name/Relationship (T)					Pural Route Number, C		
e, N 1 and Health em 27 ther tr		Shirley McGee 20a. Method of Disposition		20b. Place of Dispo		stal Bea	ach Road	Earlevil c. Location - City or 1	
Baltimore, sernit. Pages 1 a Department of He mportant: if item iny injury or othe 2008.		1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crei	natory`or other p				
Baltim permit. Pag Department Important: any injury once.		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		All Sai	NTS . Name and Add		/18/2005	Wilmingt	on, DE
Bal permi Depa impo any i		1. 4.11		F	ellows	, Helfe	nbein & N	ewnam Fu	neral
Physician		23a. Pp. 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ications that caused the ne cause on each line.			2	ac or respiratory arrest		Approximate Interval Between Onset and Death
8760, sate be executed hysician and the burial-transit	ical Examiner	daily, leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c						
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed r death. estor: After this certificate has been signed by the attending physician and estor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnanl in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnan	ісу		23d. Date of delin Month	very Day Year
rds, P		Part II. Other significant conditions co	failur					co use contribute to	the cause of death?
Division of Vital Records, i or Attending Physician: The law requires taffer death. Director: Attenthis certificate has been signed in by the funeral director, page 2 should be	Completed by	lartinsons d	isease				24a. Was an autopsy performer	d? prior to co	opsy findings available ompletion of cause of
ital	0	25. Was case referred to medical				26. Place of D	1 ☐ Yes 2 eath (Check only one)	No 1 ☐ Yes	2KI No
f Vinysici	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatier	t 3 DOA		Home 5 Residence	e 6 Other (Speci	(fy)
ion o nding Ph nth. r: After th e funeral		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Ing W	ury at ork? □ Yes 2 □ No	28d. Describe how		,,
Divis	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office	9	28f. Location (Stree City or Town, S	t and Number or Rur State)	al Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of r ner: On the basis of ex and manner stated	amination and/or in	n occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as and place, and due to	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	/ -	0		nse number	29d.	Date signed (Month,	Day, Year)
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		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type, 25/5, 2	Print) Schemi	a Are.	Lecilto.	n, md.	7,2005
Sta Regist	ate rar		32. Registrar's						

		riease i	ype or Print in Biad				•		-	
	4	For	State of Maryland /				ental Hy	giene	2005	03126
	1	- Stete Registrar		Ce	rtificate of	Death		Reg. No.		00120
Physician /Medical		I. Decedent's Name (First, Middle, Last) LUIGINA ELIZ	ABETH CATANIA				2. Date of De Month	ath Q 4	Year OS	3. Time of Death
Examiner		a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	1		County of Death	
c,		Socied Hear	+ Hospital	take de co	" COM	If Under 24 Hrs.	7	-	Hleca	
Funeral Director		6. Sec. ial Security Number 214 07 2393	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da MAY 29	th ly, Year) 19		nplace (State or Foreign untry) ALY
and .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Lo	ocation					10d. Inside City Limits
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vith the Mau t or 28a-f si be notilised Director	3	10e. Street and Number	TROB	LDUL	10f. Zip Code			10g. Citi	izen of What Co	untry?
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Steer death ver liems 234		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No Rican, etc.))~	14. Race - Amer Black, White	
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21215-00 led within 72 hou ygiene. ner than "nature nt, the medical E	-	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of workii d)	ng			
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Maryland 21215-0036 d 2 should be filed within 72 hours att in and Mantal Hygiene. Tris marked other than "natural", or traumatic event, the Medical Examitation of To Be Completed by F	ì	17. Father's Name (First, Middle, Last) MICHAEL PANTU	gn			18. Mother's Name MICHELIN			,	
should to market umatic	2	19a. Informant's Name/Relationship (Ty)		b Maili	na Addross (Stroot	and Number or Rura				in Code)
re, Maryland 21215-C s 1 and 2 should be filed within 72 h f Health and Mental Hygene. item 27 is marked other than "nature other traumatic event, the Medical To Be Completed	1	VINCENT CATANIA /	F.							
s 1 ar f Heal item item	7	20a. Method of Disposition	20b. Place o	of Dispo	erking LAG esition (Name of matory or other place	KE DRIVE,	DE I HAIN		ocation - City or 1	
Pages bent of nrt: If if		1 XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	EL'S CEMI		7/05	FROS	TBURG, N	4D 21532
Baltimore, N permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service License	7 2		2. Name and Addre			60	W. MAIN	STREET
De de la serie de		11/ardoy 71	1. Dourers			ERAL HOME,		FRO	STBURG,	MD 21532
200		23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	Α.					rrest,		Approximate Interval Between Onset and Death
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Examiner			Due to (or as a consequence	of):						9
je je		Sequentially list conditions, if any, leading to immediate case of injury	Due to (or as a consequence	of):						
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Box 687(Beath certificate to attending physical of the use as the total of the use as the use of the		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)	1		,	Month Month	Day Year
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on of \ ding Physi h. After this of funeral dir. Ton: To		27. Manner of Death	28a. Date of Injury 28b.	Time o			8d. Describe			ny)
ision Attending death. ctor: Aft y the fun		14 → Natural 5 ☐ Pending investigation	(Worter, Day Tear)	Injury		Yes 2 □No				
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certificate is hours after death. Funeral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be deteched for use as the lical Certification: To Be Completed by Physician/Medii		3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	iarm, st	eet, factory, office	2	8f. Location (City or To	Street and wn, State	d Number or Rui	al Route Number,
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Division C the Hospital or Attending P thin 24 hours after death. The Funeral Director: After the impletely filled in by the tuneral Medical Certification:		29a. Certifier 1 Sertifying Phys (Check only 2 Medical Exemir one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	nd/or in	n occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the d at the time,	date and	and manner as place, and due	stated. to the cause(s)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	2	29b. Signature and title of certifier			29c. Licens	e number		29d. Dat	e signed (Month	Day, Year)
		Men	$\sqrt{}$		02	1244		1	125/3	2005
2		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type,		1070 [icon II	V 110	2 Mr	OIE 20
		31. Date filed (Month, Day, Year)	Registrar's Signature	5	tuwy f	Mull, t	LUST	777(4,1110	SCC110
State Registrar		FEB 0 2 2005	450	Por	relie .					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra: Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death UJ Month Day Year **Physician** Carroll Johnnie Chester 26 2005 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 31, 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 6 Sex 1**√** M 2□ F Months 60 Director 220-40-1280 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-1 show the Medical Enampher must be notified at MD Allegany Cumberland 1 □XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 214 Fulton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 DYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' ury or other traumatic avant, Lto My Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Bennett's Transfer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Dyer Carroll, Sr. Thelma I. (Burgess) Vanetta ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 214 Fulton Street Cumberland Johnnie Carroll Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 remation 3 Removal from State 1/29/2005 MD Cresaptown 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician GENERALIZED CANCER UNKNOWN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner burial-transit The taw requires that the death certificate be execute Due to (or as a consequence of) Box 68760, as the burial-IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPONATREMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 X No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ٩ 1 ☐ Yes 2 📉 No Director: After this of in by the funeral dire 2X ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054946 MY

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

Boyd Sprenkle
31. Date filed (Month, Day, Year)

FEB 0 2 2005

ORIGINAL

Memorial Hospital Medical Building Cumberland MD

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	CLARK		1 - For State Registrar	State	of M	aryland /		artment of H rtificate of I		-	giene Reg. No. 0 0	5	03128
	Physici	an	1. Decedent's Name (First, Mid					-		2. Date of Dea	ath	Ye ar	3. Time of Death
	/Medi	al	Harry Lee	Chalk	aumhor)			4h Cibi Taura a	Landing of Des		27°, 200		1147 Ам
	Examir	ier	4a. Facility Name (If not institut 1523 CARSINS	RUN ROAD	питьет			4b. City, Town, or ABERDEI		m	4c. County o		
Ī	Funeral Director		5. Social Security Number 212–22–1862	6. Sex M 2 1	7. Ag	je (In yrs. last l 78	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	8. Date of Birt (Month, Pa	h Year) 7. 1927	9. Birthpl Count Mary	ace (State or Foreign Tand
	land I		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City, To	wn or Lo	cation				10	0d. Inside City Limits
	with the Maryland a or 28a-1 show Le notified at	to	Maryland Har	ford		Abero	leen						1 ☐ Yes ② ☐No
	or 28s	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of Wh	nat Count	ry?
	a 23a	ral	1523 Carsins			Section 110	10.	210			USA		
920	72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show dical Examinat canat be molithed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☆Widowed 4 □ Divorce	Armed	Forces?	Not 945-		Was Decedent of Hi f Yes, <i>s</i> pecify Cuba 1 □ Yes ※XXNo	spanic Origin? () n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		White, e	itc.
5-0	72 hours "natural",	etec	15. Decede (Specify only high	ent's Education lest grade complete	ad)	16	(Give	dent's Usual Occupa	during most of wo	orking	16b. Kind of Bus	ine <i>s</i> s/Ind	ustry
2121	id within 72 ho giene. er than "natu	Completed	Elementary/Secondary (0-12)	Colleg	e (1-4or :	5+)		ivil Serv			US Go	vern	ment
and	d be file ental Hy ced oth c event	To Be (17. Father's Name (First, Middle Harry R. (me <i>(First, Middl</i> e, Le Smith)	
aryl	shout and Me s mark umati	ř	19a. Informant's Name/Relation			15	9b. Mailir	ng Address (Street a				tate, Zip	Code)
Σ,	and 2 ealth (m 27 l		Helen Bagley	(step-dau	ghte			apidum R	d., Havr		ce, MD 2	1078	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other fraumatic event, It a M. ODGe.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		om State	cemei	ery, crer aul's	sition (Name of matory or other plac S Luthera	n Cemt.			•	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	e Licensee	Ur	nan	Ta Al	Name and Address arring—Ca Derdeen,	s of Facility rgo Fune Maryland	ral Home 1 21001-3	39 ^{P.A.}		
	Physician /Medical Examiner	er	23a-Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due	to (or as	ne.	LUSD e of):	er the mode of dying					Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		a consequence							
O. Box	requires that the death certific teen signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Liv 4□Pr	e birth	of pregnancy 2 □ Fetal dea t time of death		Ectopic pregnancy Other (specify)			23d. Date Monti		y . Day Year
Q	w requires that the been signed by should be detac	by	Part II. Other significant condi	tions contributing t	death b	ut not resulting	in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib		cause of death?
Division of Vital Records,	The law ate has b page 2 s	Completed								24a. Was a autop. perfor	sy pri	or to com ath?	sy findings available pletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medic examiner? 1 X Yes 2 No	Hospital:				Othe		ath Check on or			
1 0	ding Phys h. After this funeral di	n; To	27. Manner of Death	28a. Da	☐ Inpatie ite of Inju fonth, Da	ry 28b	Time of	t 3 DOA 28c. Injury Work	4 Nursing i	Home 5 Resid	ence 6XXQther ow injury occurred		AT SCENE
sior	ending P eath. or: After the funer	atlo		tigation tou			Injury 114	AM 101		- Bub	Kets	hot	Seef
Divi	or Att after de Direct in by 1	Certification:	3 Suicide 6 Coul 4 Homicide deter	mined 28e. PI	ace of Inj	ury - At home, c. (Specily)	farm, str	eet, factory, office		28f. Location (S City or Tow	et and Number n, State) (53		Route Number Run
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	al Examiner: On th	the best	of my knowled f examination a	ge, death	occurred at the time vestigation, in my op	e, date and place inion, death occ	e, and due to the curred at the time, d	ause(s) and manr late and place, an	er as sta	ted. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certif			u d		29c. License		2	29d. Date signed (ay, Year) 2005
	15+1		30. Name and address of perso	n who completed c	ause of d	lgath (Light 23a	ENN.	STREET, I		E,MARYLA		20,	2007
	Sta	te	31. Date filed (Month, Day, Yea		Registr	ar's Signature	1124						
	Registr	_	FEB 0 2	2005	C. 216.	ar s signature	Mos	AL)					

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Ī	Physici		1. Decedent's Name (First, Middle, Last) Edith Belle DeLauder		2. Date of Death Month Januar	y 18 20	3. Time of Death 0.5 5:35PM		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Junuar	4c. County of Dea	th		
	Funeral Director		Coffman Nursing Home 5. Social Security Number 6. Sex Home 6. Sex Home 7. Sex Home 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	ton County thplace (State or Foreign bunty) ryland		
	fand ow		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits		
	e-f sh	ctor	Maryland Washington Hage:	rstown			1 XYes 2 □ No		
	with the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?		
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Medical Hygiene. If Health and Medical Hygiene, there is no 123e or 28e-f show other treumstic event, the Medical Examinar must be notified at	by Funeral	1304 Pennsylvania Ave 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Never Married 2 ★ Married 1 ★ Yes 2 ★ No	21742 . Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Jnited S 14. Hace - Ame Black, Whit	tates oncan Indian, e, etc.		
9036	rel', or	d by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White		
Maryland 21215-0036	within 72 h ene. than "natu ne Madica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng 16	b. Kind of Business	/Industry		
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ylan	2 should be and Mental Is marked o eumatic eve	To Be	Charles William Delauder, SR.	Emma	Belle B	Brown			
Mar	d 2 sho			ling Address (Street and Number or Rura		•			
a)	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr ance.			ematory or other place)					
Baltir	permit. P Departme Importan any injury		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Dou	glas A.	Fiery Fun	n Maryland eral Home		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1331 Eastern Blvd. Inter the mode of dying, such as cardiac or Usululu // A			Approximate Interval Between Onset and Death		
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Vital		Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		-		
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Division of	l or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		8f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,		
_	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal check only one) 1. Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier AMUE (h.s.) M1)	29c. License number	29d	Date signed (Month	h, Day, Year)		
7	11 -		30. Name and address of person who completed cause of death (Item 23a) (Type 2) . CAST And TOTAL (Item 23a)		4.1.	ma an	2((1)		
ير	Sta Registr		31. Date filed (Month) Rax, Year) 2005 32. Registrar's Signature	pade	own 1	111	, 20		

			1 - For State Registrar	State of Maryland		ent of Health and ate of Death	Mental Hygien	71115	03130
i	Physici /Medic		1. Decedent's Name (First, Middle, Last	e McCovi	ner I	Pouglas	2. Date of Death Month D	ls, 2005	3. Time of Death
i	Examir		4a. Facility Name (If not institution, give 203 Davis L 5. Social Security Number 6. Se	ane	(ity, Town, or Location of Dea Tisfield der 1 Year If Under 24 Hi	ath J 4	c. County of Death	-set
j.	Funeral Director		216-12-1158 19 Usual Residence of Decedent	2M 2OF 84	Yrs. Month			-20 Col	nplace (State or Foreign intry) navyland
	death with the Maryland me 23a or 28a-f show irright be notified at	Director	Mary land Som		C v S-Fi-				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with t	al Dir	10e. Street and Number 203 Davis	Lane	10f.	Zip Code 2 1817	10g. C	itizen of What Cou	. *
5-0036	after or Ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced	12. Was Decedent Ever in U.S Armed Forces? 1 12 Yes 2 No If Yes, Give 6 - 16 - 4 Year or Dates:	If Yes, s	pedent of Hispanic Origin? specify Cuban, Mexican, Pue s 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White Specify:	
0-6121	within 72 hours ene. than "netural", ne Medical Exe	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Decedent's U	work done during most of w Tuse retired)	orking	Kind of Business/li	ore Dwner
yland	ould be filed Mental Hygi arked other attc event, I	To Be C	17. Father's Name (First, Middle, Last)	oug las		18. Mother's N	ame (First, Middle, Maide	n Sumame)	J. C. Duovi ev
Mar	nd 2 should and 27 is m		19a. Informant's Name/Relationship (T)	rpe, Print)		ess (Street and Number or F	Rural Route Number, City	2 1	nd 280
ore,	it of Healt if item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Pla Removal from State	ace of Disposition (I	Name of or other place)	Date 20c. I	Location - City or T	own, State
Saltin	mit. Pa partmer portant y injury cg.		*4 □Donation / 5 □ Other (Specify) 21. Signature of Funeral Service Licens			and Address of Facility	-22-05 +	Mard	H, md.
ñ	Dermi Depa Impo eny is		22a Boot I Enter the disease or some	- Well		39 Hampde	in any Pr.	ncess Ar	me, in 12853
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,00/	certificate be executed admin physician and be as the burial-transit	ical Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 Ectopic	c pregnancy (specify)		23d. Date of deliv	rery Day Year
as, r.	law requires that the death as been signed by the atter 2 should be delached for u	by	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlyin	g cause given in Part I.			the cause of death?
II Records,	The ate his page	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to co death?	opsy findings available ompletion of cause of
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ion oi	는 는 =	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	The state of the s	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju		79)
DIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		and the second of the second o	28f. Location (Street a City or Town, State	te)	
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			30. Name and address of per on who, or	ompleted cause of Peath (Item 2	200	D5442	351		
Ť	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 5Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kenneth Earl Davis, Sr. January 4 2005 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's 6. Sex 1 → 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 244-54-2973 Director 63 May 8, North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-1 show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Oxon Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5611 Helmont Drive 20745 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates: 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Auto Technician Private permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if Item 27 Is marked othe eny injury or other than 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Davis Ruth Hicks ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alonzo Davis - Son 4660 M.L. King, Jr. Ave, S.W. Wash., DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 1/10/2005 Brentwood, MD 4 □ Dogation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home livar 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caus—the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate : a, se (Final disease or condition resulting in death) Physician Inthroad /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last W Examiner Due to (or as a consec 07 The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Illinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: Certification: To 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Funerei 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Within 2 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 50454 son who empleted cause of death (Item 23a) (Type, Print) Name and address of pe 3-41 AV S, WOSPRINSMD 31. Date filed (Month, Day, Year) 32. Registrar's Sign Registrar

			1 - For State Registrar	State of Man	yland / Depa		lealth and M	lental Hyg	eg. No. 2005	03132				
	Physici /Media	cal	Decedent's Name (First, Middle, Last, VICTORIA MARIE DE	GRAAF				2. Date of Deat Month JANUARY	Day Year 15, 2005	9:00 P ^M				
	Examir	ner	4a. Fecility Name (If not institution, give SUNRISE ASSISTED			ANNAPOLI	Location of Death		ANNE ARUN					
(K)	Funeral Director		5. Social Security Number 6. Se:		n yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 23,	Year) 9. Birth	nplece (State or Foreign untry)				
	e-f show	tor	10a. State 10b. County MD CALVERT		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 No				
3	a or 28 be not	Dire	10e. Street and Number	_		10f. Zip Code			0g. Citizen of What Co	untry?				
	s rains should be lied within 12 hous also death with the maryland. The marked by the marked other than "naturel", or items 23s or 28e-f show other traumatic event, the Mcclical Examinat must be notilised.	by Funeral Director	1831 HATFIELD ROA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No			14. Race - Amer Black, White Specify: W					
	e. An "nature Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work ()	ing	16b. Kind of Business/I	ndustry				
5	ital Hygien d other th	Be	12 17. Father's Name (First, Middle, Last)		INSPE	CTOR	18. Mother's Name	e (First, Middle, I	MILITARY Maiden Sumame)					
	and Men is marks aumatic	ြ	VICTOR KONWICZKA 19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Maili	ng Address (Street)	MI CHAELI		City or Town, State, Z	in Codel				
	Health ar tem 27 is other trau		GERTRUDE WILLIAMS			HATFIELD								
5	nent of He int: If Item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	1	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	(e)	Date	20c. Location - City or 1	own, State				
	- 돈은 중		' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens]]		CEMETERY 2. Name and Address		3/2005	ANNAPOLIS,	MD				
3	Depa Impo eny ii		1 Thomas K. H.	Ventur	A	DAMS FUNE	RAL & CRE	MATION (CARE, 814 B	ESTGATE RD.				
	hysician /Medical xaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line. Dlmen Due to (or as a co	tia	ter the mode of dyin	g, such as cardiac (or respiratory arre	est,	Approximate Interval Between Onset and Death				
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d											
	within 24 hours after death. To the Furnaria Directors After this certificate has been signed by the attending phrompials filled in by the funeral director, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delik Month	very Day Year				
	n signed build be deta	þ	Part II. Other significant conditions con		ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?				
	ate has bee page 2 sho	Completed	Transient Is	rchemic	AHack			24a. Was an autops perform	y prior to c	opsy findings available ompletion of cause of				
	certific	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death	(Check only on	9)					
	ar this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time o	f 28c. Injury	4 K Nursing Ho		nce 6 Other (Special winjury occurred	(fy)				
	r death. ector: Afte by the fun	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Ye	At home, farm, str		Yes 2 □ No	28f. Location (Sti	reet and Number or Rui	al Route Number,				
	within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 12 Certifying Phys	building, etc. (S	v knowledge, deatl	h occurred at the tim	ne, date and place,	City or Town	use(s) and manner as	stated.				
	the Fi	Medical	Orie)	ner: On the basis of exa and manner stated	amination and/or in									
,	To	2	29b. Signature and title of certifies	7			3556		anuary 1	Day, Year) 7 2005				
			30. Name and address of person who continued the standard address of the stand	1684	Village	C.	Crofte	on, mo	21114					
	Sta		31. Date filed (Month, Day, Year)	nns 32. gistrar's	Signature	hand .		•						

			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment rtificate			Mental Hy	giene Reg. No.	05	03133
	Physici /Medi		Decedent's Name (First, Middle, Paul Marshall	DuBois					2. Date of De Month 01	Day	Yeer 005	3. Time of Death 6:45 p. M
	Examir		4a. Facility Name (If not institution, Crescent Citi			4b. City, To		ition of Death			ty of Death	eorge's
	Funeral Director		5. Social Security Number 265-12-0206		Age (In yrs. last birthday 87 Yrs.	If Under 1	Year If U	nder 24 Hrs. urs Min.	8. Date of Bi (Month, Di 02/20/	rth ay, Year)	9. Birthp Cour	place (State or Foreign ntry)
	anyland ehow	į	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					1	10d. Inside City Limits
	th the M or 28a-f	irecto	MD Prince 10e. Street and Number	e George's	Riverdal	10f. Zip C	ode			10g. Citizen o	f What Cour	1½ Yes 2 □ No
	15 wit	aiD	4409 East West	Hwy		207	737			USA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f ehow other traumatic event, If a Madical Extra instruction	l by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	12. Was Deceder Armed Forces d 1 7 Yes 2 If Yes, Give Year or Dates	s?]No	Was Deceder If Yes, specifi 1 ☐ Yes 2		ic Origin? (Sp exican, Puerto ecity:	ecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, ify: Whi	etc.
21215-0036	ithin 72 ho na. nan *natur M. dicul	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40)	(Give	dent's Usual kind of work DO NOT use	Occupation done during retired)	most of work	ing	16b. Kind of		
nd 21	2 should be filed within and Mental Hygiene. is marked other than aumatic event, It a M.	Be	12 17. Father's Name (First, Middle, L	ast)	Tecl	1	18. N	Mother's Nam	e (First, Middle	Privat , Maiden Suma		ustry
<u>y</u> la	should I	မ	K. H. DuBois					Clara				-
e, Maryland	is 1 and 2 sh of Health and item 27 is m other traum		19a. Informant's Name/Relationshi Linda H. Aiken: 20a. Method of Disposition			04 Bran	nch Vi	ew Cou		er, City or Town ver Spr 20c. Location	ing,	MD 20903
altimore,	0 0		1 ☐ Burial 2 🌠 Cremation : 4 ☐ Donation 5 ☐ Other (Spe		nomotoni oro	matory or other	er place)					Virginia
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Li	censes	1 44 10 100	2. Name and	Address of F	acility Ga	sch's F	uneral	Home,	P.A.
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that cause only one cause on each	ed the death. Do not en	ter the mode	of dying, suc	h as cardiac	or respiratory a	tsville rrest,	e, MD	Approximate Interval Between Onset and Death
8760,	Medical Examiner hysician and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ——Due to (or a	is a consequence of): is a consequence of): is a consequence of):							<i>V</i>
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetel death 3	⊒Ectopic preg ⊒Other (s <i>pec</i>	nancy ify)				ate of delive	ery Day Year
rds, P.	quires that in signed b uld be deta	by	Part II. Other significent condition	s contributing to death	but not resulting in the u	nderlying caus	se given in P	Part I.				ne cause of death?
of Vital Records,		Completed		,. <u>.</u>						an 24b.	death?	osy findings available inpletion of cause of
/ita	Icien: Pertific Bector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Death	(Check only o	one)		
on of	iding Physicien: ih. Atter this certification: funeral director,	tion: To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In	jury 28b. Time o		Other: 4			dence 6 Got how injury occu)
Division	Hospitel or Attending 44 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could no determin	ed 286. Place of in	njury - At home, farm, str etc. (Specify)	eet, factory, o	ffice		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rurai	Route Number,
	To the Hospitel or Atte within 24 hours atter de To the Funeral Directo completely filled in by th	edical (29a. Certifier 1 Certifying (Check only one)	Physicien: To the best teminer: On the basis and manner s	it of my knowledge, deat of examination and/or in stated.	h occurred at t vestigation, in	the time, date my opinion,	e and place, a death occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	2001	1/2	29c. L	icense numb			29d. Date signe		
7	x 2		30. Name and address of person W	n completed cause	death (Item 23a) (Type,	Print)	018	12		1ANUBI	ry 11,	2005 the 16
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature	421	30	veen	56 cm	14	Hya	100,16 D 2028
	Registr	ar	JAN 1 9 2005	Beer	A Apost							_

			For State Registrar	State of Maryland		artment rtificate			nd M		iene	05	0313	} Ļ
			1. Decedent's Name (First, Middle, La	st)						2. Date of Deat	h	Vana	3. Time of De	ath
	Physici: /Medic		Peter James	Douglas						January	7 15,	2005	6:20 a	1 M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, T	Town, or	Location of	Death		4c. Co	unty of Dea	th	
П			3502 Murdock Ro	ad		Kε	ensi	ngton			ľ	lontgo	mery	
	Funeral Director		5. Social Security Number 6. S 215-66-7239	ex 7. Age (In yrs. I		If Under 1 Months	1 Year Days	If Under 24 Hours	B 41	8. Date of Birth (Month, Day, Feb. 9,	^Y ear) 1951	9. Bir Ci Ja	thplace (State or Fountry) maica	oreign
	e Maryland a-f show	ctor	10a. State 10b. County		, Town or Lo								10d. Inside City L 1 ☐ Yes 2	
	or 28	Directo	10e. Street and Number			10f. Zip (11	Og. Citizer	of What Co	ountry?	
	ath w	ral	3502 Murdock R				0895				US			
920	be filed within 72 hours after death with the Maryland is Itylygiene. Is Hygiene. Other than "natural", or items 23a or 28a-f show event, I've Medical Examinat must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, special 1 Yes 2	_	spanic Origii n, Mexican, I Specify:	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, Whit Becify: Bla	erican Indian, te, etc. CK	
21215-0036	ithin 72 h ne. nan "natu nedica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give life. l	DO NOT use	k done d e retired,	lurina most a	of workin	g		of Business	•	
2	filed withi Hygiene. other than		47 Fabrus None (First Middle Land		Me	chanio				45		omobi	le	
ב	8 d a a	Be	17. Father's Name (First, Middle, Last)						(First, Middle, N	Aaiden Su	mame)		
Š	should be and Mental and Mental and marked o	P	Harold Douglas	T (D.)	400 14 77		(0)			Chew				
Maryland	C1 (C) W		19a. Informant's Name/Relationship (Myrtle Douglas/							Route Number,				
	Health Health tem 27		20a. Method of Disposition	20b. P	ace of Dispo	sition (Nam	e of	-	Da	sington			Town, State	
<u>o</u>	Pages nent of int: If It		1 🔀 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	Cat.	emetery, crer e of He	natory or ott aven Ce	mete:	∍) ¦Ja rv¦	nua: 200:	ry 21				3
Baltimore,	permit. Pages Department of t Important: If Its any injury or o		21. Signature of Funeral Service Lice	,,	Fr	Name and	Addres	s of Facility	ns F	uneral	Home	Inc	ing,Marylg, MD 209	
			23a. Part1. Enter the disease, or com	plications that caused the death								oprin	Approximate	
	Physician /Medical	8 18	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Non-Small Ce		tastat	tic	Lung (Canc	er			Interval Between Onset and Dea 19 Month	ith
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequ	ience of):									
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	nat initiated events										
99	ntifica ng ph	Med	IF FEMALE:											
P.O. Box		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pre Other (spe					230	. Date of de Month	livery Day Yea	r
	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significent conditions	contributing to death but not resu	ulting in the u	nderlying ca	use give	n in Part I.					the cause of deat	
Vital Records,	9 4 9	Completed								24a. Was ar autops perform	V	4b. Were au prior to death?	utopsy findings ava completion of caus	ilable e of
Ø	iclan: Th certificate rector, pag		OF Man case referred to medical							1 Yes 2		1 🗆 Yes	2 No	
Ē		o Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only on				
	Physical di	-	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2	28b. Time of			4 Nurs		e 5 🔀 Reside 8d. Describe ho			cify)	
O	ding h. After funer	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injusy	М	Bc. Injury Work	? ′es 2 □ No			,,	0001100		
Division	tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e con Blace of Iniversity	me, farm, str	eet, factory,				8f. Location (Sti City or Town		lumber or Ri	ural Route Number	
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	edical	29a. Certifier 1 ☆ Certifying Pl (Check only one) 2 ☐ Medical Example (Check only one)	nysicien: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, death	place, a occurre	nd due to the ca d at the time, da	use(s) an ite and pla	d manner as ace, and due	s stated. to the cause(s)	
	To t To t	Ž	29b. Signature and title of certifier	11 . 04 .				number		25			h, Day, Year)	
ł	lo			and and			0332	24			Janu	ary 1	7, 2005	
	4		30. Name and address of person who											
			Ram Trehan, M.				riv	e, #30	3, 1	Rockvil:	le, M	ID 2085	52	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2	324 Registrar's Signa	L So	uli								

			1 - For State Registrer	State of M	aryland / Depa <i>Cel</i>	artment of		and Mental Hy	giene Reg. No 20	15 03135
	Physic		1. Decedent's Name (First, Middle, Last Robert Alan Da					2. Date of D Januar	eath	3. Time of Death 5:40 a M
	/Medi Examii		4a. Fecility Name (If not institution, give)	4b. City, Town		of Death	4c. County of Harf	Death
	Funeral Director		5. Social Security Number 6. Se 212-52-9261	X 7. A	ge (In yrs. last birthday) 49 Yrs.	If Under 1 Ye Months Da		8. Date of B. Month C. 10/24/	irth 1955 M	9. Birthplace (State or Foreign Country) aryland
,	the Maryland 28e-f show	rector	10a. State 10b. County Maryland Harford 10e. Street and Number		10c. City, Town or Lo		A		10g. Citizen of Wh	10d. Inside City Limits X⊠ Yes 2 □ No
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Items 23a or 28e-f show any highty or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	1110 Main Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 20 If Yes, Give Year or Dates:	? No		21034 of Hispanic Original Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	USA o- 14. Race -	American Indian, White, etc. White
121215-0036	iled within 72 ho tygiene. ther than "natu nt, the Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	cation e <i>completed)</i> College (1-4or	(Give life.	dent's Usual Ock kind of work do DO NOT use rel ACCOUNT	ne during most tired) ant		16b. Kind of Busi	ing
Maryland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than "raumatic event, the Mark	To Be	Frank C. Dare 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Stre	Dor	r's Name (First, Middle othy Shaw or or Rural Route Numb	7	
	Pages 1 and 2 nent of Health a snt: If Item 27 Is ury or other tra		Kira Dare (wife) 20a. Method of Disposition 1 Burial 200 remation 3 F	Removal from State	P.O 20b. Place of Dispo	. Box 2	17 Darl	ington, MD		
Baltimore,	permit., Pa Depertmen Importent any injury once.		21. Signature of Funeral Service Licens	·· 5. 20	R.A.Ferri			/28/2005 uneral Hom and 21001-	West Ches e. P.A. 3399	ter, PA
8760,	The law requires that the death certificate be executed: The law requires that the death certificate be executed: It has been signed by the attending physician and a sage 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	1 O F	pying, such as of	ECTUM		Approximate Interval Between Onset and Death
.O. Box 6	at the death certifica by the attending pl tached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnal			23d. Date of Month	,
Δ.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death b	out not resulting in the ur	nderlying cause	given in Part I.		_ /	te to the cause of death? ☐ Probably 4 ☐Unknown
Vital Records,		Completed						24a. Was auto perfo 1 \(\text{Yes}	psy prio	re autopsy findings available or to completion of cause of th? Yes 2 \(\subseteq \) No
of	ding Phys h. After this funeral dii	ation; To Be	25. Was case referred to medical examiner? Yes 2 No F	of Death (Check only sing Home 5 President 28d. Describe		(Specify)				
Division	P Si te o	Certification;	3 Suicide 6 Could not be determined	building, et	ury - At home, farm, stre c. (Specify)			City or To	wn, State)	or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Examin 29b. Signature and title of Certifier	sician: To the best ner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	estigation, in my	time, date and y opinion, death	place, and due to the noccurred at the time,	cause(s) and manned date and place, and 29d. Date signed (A	I due to the cause(s)
	15		30. Name and address of person who co	mpleted cause of c	leath (Item 23a) (Type, I	- 2	13/7	75 BELAI	JANUAR ROA	27,2005
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 20	32. A gistr	ar's signature	rades	AU	510N L	naryi	AND (/

State of Maryland / Department of Health and Mental Hygiene 005

					eπιτιcate o	T Death		Reg. No.		
Phy	sician	Decedent's Name (First, Middle,					2. Date of D Month	eath Day	Year	3. Time of Death
/M	ledical	Shirley Ann Ever 4a Facility Name (If not institution,				4. 07. 7	Janua			11:10 PM
Exa	aminer					4b. City, Town, or				
-		Williamsport Nur 5. Social Security Number		ge (In yrs. last birthe	day) If Under 1 Yea	Williams			ningtor	
Fune Direc		220-28-8764	1 M 2 XF	V-	Months Day		. (Month, E	Day, Year)	9. Birthpla	ice (State or Foreig
4 6	.101	Usual Residence of Decedent		68 "			Mar.	13,1936	Pennsy	/Ivania
yland	4	10a. State 10b. County		10c. City, Town o	or Location				100	d. Inside City Limit
Mar 1	Į į	Maryland Washir	naton	Hagerst	own					1 ☐ Yes 2 ☑ No
h the	i e	10e. Street and Number	J	<u> </u>	10f. Zip Code)		10g. Citizen of	What Countr	y?
be filed within 72 hours after death with the Maryland tal Hyglene. Onder then "natural", or ferme 23a or 28a-f show of other then "matural" and other then a notified a showly the months of the notified as well.	a o	11337 Rock Hill	Road		2174	0		USA		
deat	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent o		Specify Yes or N	lo- 14. Ra	ce - Americar	
after or its		1 ☐ Never Married 2 ☐ Married		No			to Hican, etc.)		ick, White, et	c.
ral.	ğ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠N	o Specify:		Specif	y: Whit	te
72 h	Be Completed by	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usual Occ	upation	rkina	16b. Kind of B	usiness/Indu	stry
ithin	d d	Elementary/Secondary (0-12)	College (1-4or !	5+)	sive kind of work don fe. DO NOT use reti	red)	n Kuig			
ygier th	S	10	0	Man	ager			Horse	Racino	1
d off	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Na	me (First, Middle	e, Maiden Sumar	ne)	
should be filed value of Mental Hygie marked other to	2	Walter Harry Mir	nnich				Ernest			
2 sh and lam		19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Address (Stre	et and Number or R	ural Route Numi	ber, City or Town	, State, Zip C	ode)
and 2 aaith a n 27 is		Dianna L. Osborn	ie (Daughte		39 Rock H	ill Rd. H	agersto	wn, Mary	land	21740
of H	5	20a. Method of Disposition 1 Burial 2 □ Cremation 3	□ Pamoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other p	lace)	Date	20c. Location	· City or Town	n, State
Peges nent of land: If Ite	5	4 □ Donation 5 □ Other (Spe		Rest Ha	ven Cemet	ery Jan	25,2005	Hagerst	own. N	Mary Land
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Importament of Haatih and Mental Hygiens (Importants If New 72 in marked other than "natural", or fleam 23a or 28a-1 show any Injury or other traumatic event; the Medical Exercise.	OUCe.	21. Signature of Funeral Service Lie	(n) ee		22. Name and Add Osborne F	ress of Facility	m = D A	42E C	C	-1
82 = 2	9	Dutill ()	Mu	_	Williamsp	ort Mary	land 21	420 S.	Conocc	cneague
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not	enter the mode of d	ying, such as cardia	c or respiratory	arrest,	A	pproximate iterval Between
Physicia	an	SHOCK, OF HEART FAILURE. LIST OF	ly one cause on each in	ne.					In O	nterval Between Inset and Death
/Medic	_	Immediate Cause (Final disease or condition	Escala	2221	Cancer				1	1 200
Examin	ner	resulting in death)	a. Esoph	Due to (or as a cor	sequence of):					1 months
ъ ≃	ne l								1	
acute ind tr: ns	E E	Sequentially list conditions,	b	Due to (or as a con	sequence of):					
law requires that the death certificate be assecuted es been signed by the attending physician and 2 should be datached for use as the bunal-trinsit	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							i	
v requires that the death certificate be assecuted been signed by the attending physician and should be datached for use as tha bunal-tr. neit	an/Medical Examiner	that initiated events resulting in death) Last	C	Due to (or as a con	sequence of):					
entific ling p	S		1 d							
ath c ettenc for us	ian							11 - 2 - 1h		
the a	by Physici	Part II. Other significant conditions	contributing to death be	ut not resulting in th	e underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of death
hat the ed by detac	吊	deep venous	thomahosis				1 🗆	Yes 20 No	3 Probab	bly 4□Unknow
ries ti signe	b	000	111 01110031		·					
neen	Completed						24a. Was	an autopsy ormed?	availa	autopsy findings
law les b e 2 s	d d			-				- /	of dea	eletion of cause ath?
The late he	Š						10	Yes ZUNO	1 □ Y	′es 2□ No
nysician: The law his cartificate hes l I diractor, pege 2 s	Be	25. Was case referred to medical examiner?				26. Place of Dea				
Physician: rthis cartific rral diractor,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		tient 3□ DOA O	ther: 4 D Nursing H	lome 5□ Resi	idence 6 □Oth	er (Specify)	
	 	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Y (28b. Time (Year) Injur	e of 28c. Inj	ury at ork?		how injury occur		
ent or:	cati	2 Accident investigati			M 1[Yes 2□No				
D C O	. E	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, c. (Specify)	street, factory, office	•	28f. Location (City or To	Street and Numb wn, State)	er or Rural R	oute Number,
rel D	S						,			
To the Hospital or within 24 hours effe To the Funeral Dir complately filled in	edicai	(Check only 2 Medical Ext	Physician: To the best of aminer: On the basis of	examination and/or	eath occurred at the t	ime, date and place	, and due to the	cause(s) and ma	nner as state	id.
the I the I	Med	uney	and manner sta	ted.						
5 ₹ 5 200	~	29b. Signature and title of certifier	11Th 0= -10	2-1	29c. Licer	ise number		29d. Date signer	i (Month, Day	v, Year)
		- upmma n	, wy - c 6	and the	DA	1751		ianuary	21,2	005
		Cynthea K 30. Name and address of person who Cynthea Kutther-	completed cause of de	eath (Item 23a) (Typ	De, Print)	an Stree	t. w.11	Iamson	rt M	aryland
1-8		Cyntha Kuttner-	SONDS MD	154 Nor	The Allian		1	217	135	1
	State	31. Date filed (Month, Day, Year)	2005 32. Registre	n's Signature	1.			-		
Regi	ictrar	TO THE TWO AS	-VUU	44 /9	11 - 11 2					

DHMH 16 Rev 6/95

		1 - State Registrar	<i>i.e.a.</i>	-,		•	artment of F tificate of			Reg. No.	005	0313	
Physici /Medi		1. Decedent's Name (First, I Charles E. E		,					2. Date of De Month January	Day	Year 2005	3. Time of Death	
Examir	ner	4a. Facility Name (If not insti	-					r Location of Death	1	4c. Cou	inty of Deeth		
	3 1 11 1 - 1	Corsica Hil. 5. Social Security Number	LS Nu		e (In yrs. last b	imbodos (Centre		O Date of Rie		n Anne		
Funeral Director		222-14-4723 Usual Residence of Decede	1	ŽM 2□F	82	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct. 29,	19, Yeer) 1922	MD	place (State or Foreig Intry)	
ms 23a or 28a-f show	J.	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 ₩ Yes 2 □ No			
288-I	Director	10e. Street and Number		are 5		Quee	10f. Zip Code			10g Citizen	of What Cou	- A	
3a or	Ö	113 Scottown	Road				21658			USA		,	
"natural", or items 23a or 28a-f show coloal Examiner must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 3 Widowed 4 Dive		12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:		11	Was Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.) 14. Race - Arr Black, Wh Specify: B1			, etc.	
nature odical E			edent's Ed lighest gra	lucation de completed)	16	a. Deced	lent's Usual Occup kind of work done	ation during most of word	king	ndustry			
r than	Completed	Elementary/Secondary (0-	12)	College (1-4or	5+) C			rker	Hospitia			ty	
d other if	Be	17. Father's Name (First, Min						18. Mother's Nam	ne (First, Middle,	Maiden Sun	name)		
ind Mental marked c umatic eve	2	Herman Ellio	tt					Addie (Cooper				
Tra tra		19a. Informant's Name/Rela Jennifer Dun			1.			and Number or Ru Ave., Ce					
Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 XBurial 2 ☐ Crema			cemet	ery, cren	sition (Name of natory or other place		Date		on - City or T		
rtmer rtant njury		* 4 □ Donation 5 □ Oth			Mt. P.			ery Jan.	.20, 200	Bond 1	Cown, l	MD 	
Depa Impo any i		21. Signature of Funeral Se	/	500			Name and Addre		1 & Newn	am Fur	eral I	Home, P.A.	
nysician Medical xaminer		23a. Fant1. Enter the disease hock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or comp List only	a Pu	the death. Done. Unio a consequence	not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading or immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.											
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								ery Day Year			
gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions.						ontribute to t	he cause of death?				
en sig	ed	Wed en	14	with s	eft a	Low	mps w	13	101	Yes 2 No	3 ☐ Prol	bably 4 Unknows	
ite has be	Completed	24a. Was an autopsy of the strength of the str							prior to co	opsy findings available			
ctor.	BeC	25. Was case referred to me examiner?	edical	27000				26. Place of Dea				22.10	
h. After this co funeral dire	2	1 ☐ Yes 2 1 No 27. Manner of Death 1 ☐ Natural 5 ☐ P	ending	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		outpatient Time of Injury	Wor	at k?	ome 5 Resid			(y)	
s after deal	Certification:	2 Accident investigation 3 Suicide 4 Homicide All Homicide Since the determined Since							mber or Rura	al Route Number,			
n 24 hour se Funer, sletely filk	edical (29a. Certifier 1 Des (Check only one)	tifying Ph dical Exam	ysician: To the best niner: On the basis o and manner st	f examination a	ge, death and/or inv	occurred at the ting restigation, in my o	ne, date and place, pinion, death occui	and due to the gred at the time,	cause(s) and date and plac	manner as s	stated. o the cause(s)	
withir To th comp	Me	29b. Signature and title of co		-, mo			29c. Licens	e number 213/3 we., Co		29d. Date sig	ned (Month,	Day, Year)	
	1	14 -1:		, , , , , , , , , , , , , , , , , , , ,	leath (Item 23a)	_	-				, -		

			1 - For State Registrar	State of	Marylai		artment of		ind Ment		4.00	5 03138
			Decedent's Name (First, Middle, La	ist)			imouto o	Douth	2. D	ate of Death	g. No.	3. Time of Death
П	Physici		A 0	•	_	_			N	lonth	Day Ye	ar 1.20 av
	/Medic		Agnes The Agnes Ag	neadores		Faunce	4b. City, Town	ar Lagation of		nuary		J
	Examir	ıer	St. Mary's Hospital				4b. City, Town,				4c. County of D	
-					Ann (In um	last birthday)	If Under 1 Yea		rdtown	10:0		. Mary's
Г	Funeral Director			1□M 2●F	81	Yrs.	Months Day		Min. (A	ate of Birth Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
h			Usual Residence of Decedent		01				Sep	t. 11	, 1923	Maryland
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Many	jo	Maryland St. N	Mary's			Loona	rdtown				1 ☐ Yes 2 ■ No
	the 28a	Director	10e. Street and Number	laly 5			10f. Zip Code			10	g. Citizen of What	Country?
	with sa or	٥	No. of the contract of the con	C						10		
	leath	era	22680 Cedar Lane	12. Was Deced	ent Ever in I	IS 13 V		0650	in? (Specify)	(ac as No		d States
	fter o	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Ford	es?	, , , ,	Was Decedent of f Yes, specify Cu	ban, Mexican,	Puerto Rican	, etc.)	Black, W	kmerican Indian, √hite, etc.
8	urs a	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dat	. TT		I□Yes 2₩N	o Specify:			Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ant, the Maritgal Examinar must be notified at	Completed	15. Decedent's E	ducation		16a. Deced	ient's Usual Occi	upation	-	16	6b. Kind of Busine	ass/Industry
7	7 nir 7	pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4	(a. F.)	(Give	kind of work don OO NOT use retii	e during most red)	of working			, od mod stry
5	d with	E	11	College (1-4	+01 3+)	N	urse's	Aide			Healt!	hcare
ğ	othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother	's Name (Firs	t, Middle, Ma	aiden Sumame)	
Maryland	Ald by Alenta Alenta rked	To E	Bernard Ridge	11					Agnes	Matt	ingly	
ary	shou and A s ma uma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Stree	et and Number	r or Rural Rou	te Number, (City or Town, Stat	e, Zip Code)
	alth a		Wm. Kenneth Faund	ce, Sr. /	' Son						, Maryla	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Maritial Examinal must be notified at once.		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pl	1	Date		Oc. Location - City	
Ē	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special		ate			,	1 21 20	NO 5 G1	_	
altimore,	artm orte		21. Signature of Funeral Solide Lice	2009 1	DI	Instiet	Name and Add	ress of Facility	Princf	OD CE	narlotte	Hall, MD Home, P.A.
ñ	Per Per Per Per Per Per Per Per Per Per		Edward N. Brinsfi	eld, Jr.	M000							
			23a. Part1. Enter the disease, or com				er the mode of d	ing such as c	ROad,	Leonar	dtown, M	1D 20650-0279 Approximate
ı			shock, or heart failure. List only Immediate Cause (Final	one cause on ead	n line.		,	,,		matory arros	***	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	SEP							Days
	Examiner			Due to (or	O A	quence of): 4 mon						0975
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consec		1					
	uted I Insit	Examiner	Cause. Enter Underlying Cause (Disease or injury		CH							0975
	execu n and al-tra	xal	that initiated events resulting in death) Last	C. Due to (or	as a consec							
98760	eath certificate be executed attending physician and for use as the burial-transit	Sail	(d								
89		edicai		d								
Box	law requires that the death certif as been signed by the attending 2 should be detached for use a:	Physician/M	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outco							23d. Date of	delivery
	res that the death cer igned by the attendin be detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☑No		h 2∏Feta ntattime of d		Ectopic pregnant Other (specify)	су			Month	Day Year
J.	t the	hys	9 🗆 Unknown	9L Unknow	rn							
	s tha	by P	Part II. Other significant conditions of	contributing to dea	th but not res	ulting in the un	derlying cause g	iven in Part I.	2:	3e. Did toba	cco use contribute	to the cause of death?
Vital Records,	w require been sig should b									1 🗌 Yes	2 □ No 3 □	Probably 4 DUnknown
ပ္ပ	s bee	Completed							24	4a. Was an	24h Were	autopsy findings available
¥	The la	mo								autopsy performe	ed? prior to death	to completion of cause of ?
<u>e</u>	ifficat or, pa	ပိ	25. Was case referred to medical								No 1□Y	es 25 No
	hysicien: The law nis certificate has I I director, page 2 s	ToB	examiner?	Hospital:	ationt 2	ER/Outpatient	05		of Death (Che			
DIVISION OF	<u>a</u> = a		27. Manner of Death	28a. Date of	Injury	28b. Time of	3□ DOA 28c. Inju	4 U NUIS			ce 6 Other (S)	pecify)
0	ding It. th. : After s funer	tio	1 Natural 5 ☐ Pending investigation	(Month,	Day Year)	Injury		ork?]Yes 2.⊟No	i		,,	
/ISI	or Attendi after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of	Injury - At he	ome, farm, stre				cation (Stree	et and Number or	Rural Route Number
S		Certification:	4 Homicide	building	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street an City or Town, State							
	te Hospitel or At 124 hours after of 18 Funerel Direct Metely filled in by		29a. Certifier Certifying Ph	ysician: To the be	est of my kno	wledge, death	occurred at the t	ime, date and	place, and du	e to the caus	se(s) and manner	as stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical Examone)	niner: On the basi and manne	s ot examina	tion and/or inv	estigation, in my	opinion, death	occurred at the	ne time, date	and place, and d	ue to the cause(s)
one) and manner stated. 29c. License number							29d.	. Date signed (Mo	onth, Day, Year)			
			▶ OBhay				D6	1719		.T	anuary 2	8. 2005
		Ì	30. Name and address of person who	completed cause	of death (Item	n 23a) (Type, F						-, 200 <i>3</i>
	-		Dhananjay Bhavs	ar, M.D.	2403	5 Three	Notch	Road. I	Hollvwo	od. M.	arvland	20636
	Sta	te	31. Date filed (Month, Day, Year) JAN 2 8	2005 32. Red	strar's Signa	ture	e 100					
	Registr	ar	JAN Z O	-003		15						

		1 - For State of Maryland			ealth and N	Mental Hyg	2000	03139
		Decedent's Name (First, Middle, Last)				2. Date of Deat	eg. No.	3. Time of Death
Physi		Pauline Mae Finneyfrock				Month January	Day Year	
/Med		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Doath	<u> </u>	4c. County of Death	8:05 A M
Exam	ıırıęr	Frederick Memorial Hospital					Frederic	•
Funces		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)	Frederi	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Funera Directo		1 N 2 M E	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, January	Year) , 1925 Mar	yland
/land			, Town or Lo	cation				10d. Inside City Limits
Man	ģ	Maryland Frederick Thur	rmont					1 Yes 2 □ No
r 288	Directo	10e. Street and Number	LIIIOH L	10f. Zip Code		10	Og. Citizen of What Cou	ntry?
3e O		16 W. Main Street		21700				•
death ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	S. 13. V	21788 Was Decedent of His f Yes, specify Cuban	United Stat	ed States Race - American Indian,		
or He	Ē					Rican, etc.)	Black, White,	
urs a	2			1 ☐ Yes 2X No	Specify:		Specify: Whi	.te
5-UU30 72 hours after death with the Maryland neturel', or Items 23e or 28a-1 show diest Examiner must be nutified at	Completed	15. Decedent's Education	16a. Deced	lent's Usual Occupat	tion		16b. Kind of Business/In	dustry
Med " "	90	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done du DO NOT use retired)	iring most of work	ang		
A de will	Ö	7	Homem	aker			Own Home	
and d be file ental Hy sed oth c event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
Ments Aents rked tic e	Į,	Lloyd Eyler			Oma Ride	nour		
Mary d 2 sho th and N 7 is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street ar	nd Number or Rui	ral Route Number,	City or Town, State, Zip	Code)
DESILIMICTE, METYIATIC ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-1 show eny injury or other treumetic event, the Medical Evantine must be nutilised at		Jim Finneyfrock / Son	1171	4 Brookda	le Drive	/Waynesb	oro.Pennsvl	vania 17268
s 1 a		0.0	ace of Dispo	sition (Name of natory or other place	1		20c. Location - City or To	
Page ent c nt: If		Abunal 2 Cremation 3 Hemoval from State				- 20 2005	m .	. 1 1
SALLIMOR Dermit. Pages Department of mportent: If it	oj	21. Signature of Fugeral Service Licensee	22	Cemetery . Name and Address	of Facility C+	y AU, AUD	Thurmont,	Maryland
a garage	ğ /	1 Xh				aurrer F	uneral Home	S, P.A.
		23a. Part Enter the disease of complications that caused the death	Do not ente	er the mode of dvina	. such as cardiac	or respiratory arre	ont,Marylan	Approximate
	1			,			,	Interval Between Onset and Death
Physiciai /Medica		disease or condition resulting in death)		1+2m	ORRHA	62		3days
Examine		Due to (or as a consequ	ence of):					,
	1	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ	ence of):					
ted	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				A	8.	
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oo/ fiicate p phys	dic	d			2000	~ 9x		
certification ding	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnar	ncv		HOV.	1	001.0	
BOX Bath cer attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	death 3□	Ectopic pregnancy Other (specify)	1	2	23d. Date of delive Month	Day Year
ched the d	VSic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown		Citiei (specifi)	1			
The COLOS, P.O. BOX of The law requires that the death certification has been signed by the attending place 2 should be detached for use as the			Iting in the ur	nderiving cause awer	inchail	23e, Did tob	acco use contribute to the	ne cause of death?
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	CO		V^{\dagger}			perform 1 ☐ Yes 2	No 1 Yes	2□ No
VITAL icien: T certificat ector, p	B	25. Was case referred to medical examiner?				h (Check only one)	
Physic this craldin	۵		ER/Outpatien		4 Li Muising He		nce 6 □Other (Specif	y)
ding Ph. After thi funeral	Certification:	1 □Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury : Work?	at	28d. Describe ho		
OVISION Or Attending after death. Director: Afte	cat	2 Accident investigation 01/15/05 3 Suicide 6 Could not be 28e, Place of Injury - At hor	10:00	A	es 2 No		and fell on	
or At Ster d Street		4 Homicide building, etc. (Specify,)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura , State)	Il Route Number,
urs a		Residence				16 W. Ma	in St. Thur	mont, MD
the Hospital or Attending Physicien: nin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,	edicai	29a. Certifier (Check only 2 Medicel Exeminer: On the basis of examination	vledge, death	occurred at the time	, date and place, nion, death occur	and due to the ca	use(s) and manner as s te and place, and due to	tated.
To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Med	and manner stated.						
To	2	29b. Signature and title of certifier Mely Viumn M.D.		29c. License			d. Date signed (Month,	
(1)		/ fell vam 11.0.		V 51	176		SANUARY	20, 2003
11/	/	30. Name and address of person who completed cause of death (Item	23а) (Туре.	Print)				
		Lalit Verma, M.D. 400 West	7th St	treet Fre	derick.	Maryland	1 21701	
	State	31. Date filed (Month, Pax, Year) 0 2005 32. Registrar's Signate	пь	locall s	,			
Regis	strar		Town of the last	To see the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiphel [] 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Elnora Lahoma Field Jan 28, 2005 /Medical 10:35pm 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Allegany County Nursing Home Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 XF 217-05-0436 Yrs. 90 Director Aug 27 WV Usual Residence of Decedent death with the Maryland works 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23a or 28e-f shov the Medical Examiner must be notified at MD Allegany Cumberland Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15307 Bottle Run Road 21502 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 is marked other than "netural", or item ury or other traumatic event, the Medical Evantural 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Luke Paper Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon Green Margaret Heatley Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Blank daughter 14028 Mt. Savage Rd Mt. Savage MD 21545 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Importent: If any injury or once. Sunset Memorial Park 2/1/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCLEROTIC HEART DISEASE 2010 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) acomo James, 200Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m Robustiano Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502 State FEB 0 3 2005 Registrar

		1 - For State Registrar	State of	Marylar	nd / Dep <i>Ce</i>	artment o	of Health of Death	and M ท	lental Hyg	jiene eg. No.	005	0314	.		
- · · ·		1. Decedent's Name (First, Middle, La	ast)						2. Date of Deat Month	th Day	Year	3. Time of De	eath		
Physicia /Medic		JOHN BERNARD FAI	RRELL						January		2005		M		
Examin		4a. Facility Name (If not institution, given	ve street and numb	er)		4b. City, Tow	n, or Location	of Death		4c. 0	County of De	ath			
		Fairland Nursing	g Home				r Sprin			Mo	ontgom	ery			
Funeral			Sex 7. 1⊠M 2□F		last birthday)	Months Da	ear If Under ays Hours	r 24 Hrs. Min.	 Date of Birth (Month, Day) 	, Year)		irthplace (State or F Sountry)	Foreign		
Director		3/9-22-2331	124	79	Yrs.				Feb. 3,	192	.4 Mai	ryland			
and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside City	Limits		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examination at parties and 2008.	ō				1 1							1 X Yes 2	□ No		
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r Her	Ξ	1 Never Married 2 Married		^{8s?} □No 194	43-	If Yes, specify (Rican, etc.)		Black, Wh	nite, etc.			
el', o	5	3 Midowed 4 Divorced	If Yes, Give Year or Date	s:1946		1 ☐ Yes 2💢	No Specify	<i>/</i> :		1	Specify: W	hite			
2 should be filed within 72 hours after death with the Maryland and Menlar Hygiens. Is marked other than "naturel", or Items 23s or 28s-f show sumatic event, the Moderal Examinating must be mailfined at	Completed	15. Decedent's E (Specify only highest gr				dent's Usual O		st of worki	ina	16b. Kin	d of Busines	s/Industry			
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l and lealth im 27 her t		Linda B. Shugrue	- Daugh			4 Caled						or Town, State	0874		
ges tof h		1 ☐ Burial 2 ☐ Cremation 3 [Removal from St	ate	cemetery, cre	matory or other	place)								
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permit Depar Impor any in		21. Signature of Funeral Service Lice	enseer	11000					sch's Fu						
ED = a a		Malane //12	whome	1013					., Hyatt		lle, M				
		23a. Fart1. Enter the disease, or con shock, or heart failure. List only	nplications that cau y one cause on eac	ised the deat th line.	th. Do not en	ter the mode of	dying, such as	s cardiac c	or respiratory arr	est,		Approximate Interval Betwee Onset and Dea			
Physician		Immediate Cause (Final disease or condition	a. Conge	stive	Heart	Failure						01100(4110 000	441		
/Medical Examiner	_	resulting in death)		as a consec											
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eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregn	ancv					23d. Date of delivery					
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sicie certi recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ationt OF	ER/Outpatie	nt 3 DOA	Other		n <i>(Check only on</i> me 5□ Reside		□04baa (C-				
ding Physicien: h. After this certific funeral director,	⊢	27. Manner of Death	28a. Date of	Injury	28b. Time of		Injury at	-	28d. Describe ho			юспу)	-		
ding th. Afte	tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐	No							
el or Attending P s after death. I Director: After t d in by the funera	ertification:	3 ☐ Suicide 6 ☐ Could not I	4 280. Place o	f Injury - At h	ome, farm, st	reet, factory, of	fice				Number or I	Rural Route Number	Hr,		
after Dire	erti	4 Homicide	building	, etc. (Speci	fy)				City or Town	n, State)					
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	al C		hysicien: To the b												
e Ho 124 P e Fu letely	edical	(Check only 2 Medical Exa	miner: On the bas and manne		ation and/or in	nvestigation, in I	my opînion, de	ath occurr	ed at the time, d	late and p	place, and du	ue to the cause(s)			
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> = 0		> 1011X		_		DO	058962			Jan	uarv 1	7, 2005			
4		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type		930702			3 3411		. , 2005			
)		Shashank G. Pate					. Wheat	ton	Marylan	d 20	902				
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Amend item#26 - statePer Phy 1/25/0!	State of Ma	aryland / Dep	partment of Hertificate of L	ealth and Death		ene 005	03142	
		3	Decedent's Name (First, Middle, Last)				-	2. Date of Death		3. Time of Death	
	Physici		David Legnard Fletcher	•				January 23	Pay Year	11:30 AM	
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Dea		4c. County of Dea	/	
	LAGITIT		1901 Colora Road			Colora			Cecil		
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last birthda		If Under 24 Hi	s. 8. Date of Birth	year) 9. Big	thplace (State or Foreign	
	Director		245-60-4760	M 2□F	61 Yrs.	Month's Days	Hours Wil	May 8,	1943 Nort	h Carolina	
	p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	shov	٦			Too. Oily, Town of					1 ☐ Yes 2 🖺 No	
	he M	Director	MD Cecil 10e. Street and Number		<u> </u>	Colora		10	g. Citizen of What C	ountry?	
	with a						747	100		out in y :	
	eath	era	1901 Colora Road 11. Marital Status	2. Was Decedent	Ever in U.S. 1:	3. Was Decedent of Hi	917	(Specify Yes or No-	U.S.A.	erican Indian.	
336	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Itams 23a or 28a-f show avant, the Medical Examinant must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2XI No	Specify:	arto Rican, etc.)	Black, Whi	te, etc.	
ŏ	2 hou	ted	15. Decedent's Educ	ation	1 16a. Dec	cedent's Usual Occupa	ation	meting 1	6b. Kind of Business	Industry	
215	within 7 ene. than "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or:	5+) (Gr	ve kind of work done of DO NOT use retired	i) I)	roiking			
2	e filed within al Hygiene. other than ' vant, Lie we	Completed	12	0	I	Ingineering	4		JS Governi	ment	
p	be filed tal Hygird of other avant, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, M	aiden Sumame)		
<u>ya</u>	2 should be and Mental is marked sumatic av	ပ	Unknown					y Barnwell			
<u>Ja</u>	2 sh and lsm	g. 3	19a. Informant's Name/Relationship (Typ					Rural Route Number,			
e,	s 1 and 2 should f Health and Men ltam 27 is marke other traumatic		Sandra B. Fletcher 20a. Method of Disposition	_(Wife)		COLOTA RO position (Name of	bad, Co.	lora, Mary	Land 2191 Oc. Location - City o		
nor	ages int of t: If Its y or o	1	1X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, c	ingham Cemete	1		olora,Maryla		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra		21. Signature of Funeral Service License	9 10	T	22. Name and Addres	s of Facility	eral Home,	P.A.		
	205 20		place.	Dell	man :	333 South 1	Parke S	t., Aberde	en, Maryla	and 21001 Approximate	
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each l	ne.	enter the mode of dyin	g, such as card	ac or respiratory arres	ši,	Interval Between Onset and Death	
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687	physi physi s the l	dical	d								
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome					23d. Date of de	livery	
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Records, I	The law requires that the death centificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions con	tributing to death t	out not resulting in the	underlying cause give	en in Part I.			o the cause of death?	
cor	w requir been si should	ete						24a. Was an	24b. Were a	utopsy findings available	
Re	The laverete has	ompleted						autopsy perform	ed? prior to death?	completion of cause of	
Vital	ician: certifice rector, p	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only one)		
of V	d is	10	1 Yes 2 No	ospital: 1 🔲 Inpati	ent ZELVOutpat	ont 3 DOA	er: 4 🗌 Nursing	Home 5 Hesider	nce 6 Other (Spe	ecify)	
		on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ty Year) Injur	y Worl	k?	28d. Describe how	v injury occurred		
Sio	Attanding of death.	cati	2 Accident investigation 3 Suicide 6 Could not be	20a Diana of In			Yes 2 □ No	39f Logation /Sta	not and Number or F	lural Doute Alumbor	
Division	_ O = _	Certification:	4 Homicide determined		jury - At home, farm, tc. (Specify)	street, factory, office		City or Town,	eet and Number or F State)	urai noute Number,	
	To the Hospital o within 24 hours aft To the Funaral Di completely filled in	edical (of examination and/or			ice, and due to the car courred at the time, da			
	To the within 2	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)	
			Jose 1/16	· MI)	D4	4716).	enuary.	24,2005	
			30. Name/and address of person who co						22.2	7	
			31. Date filed (Month, Day, Year)	32 Benie		wite 31	4, E	1Kton,	MD	21421	
	Sta Regist		JAN 2 5	2005	Par's Signature	Coules					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 03143 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JAN. **Physician** 14, 2005 SANDRA FOREMAN 8:15 AM L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY Rockville Shady Grove Adventist Hosp If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Days 1 ☐ M 2 🔀 F 230-53-5676 61 Virginia Director Aug. 23, 1943 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any july or other traumatic event, the Medical Evantment will be multiled at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MDMontgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 U.S.A. 12021 Cheyenne Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3X Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 2 yrs Elementary/Secondary (0-12) Unemployed None yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agenora Boyd Sherman L. Hatchett, Sr. 2 Sister = 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20877 Adrienne Hatchett (in-law) 12021 Cheyenne Rd., Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burjal 2 ☐ Cremation 3 ☐ Removal from State 1-21-05 4 Donation 5 ☐ Other (Specify) Resthaven Cem. Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home, 246 N. Washington St., Rockville, MD 20850 enter the mode of dying, such as cardiac or respiratory arrest.

Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Brainstem Stroke Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an performed' 1 Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2X No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 🛣 Natural 1 ☐ Yes 2 ☐ No 2 🗋 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w D58621 Jan. 14, 2005 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, MD 20850 M.D. Jude Alexander, egistrar's Signature 31. Date (iled Month, Day, Year) 32 State JAN 2 0 2005 RICHE Registrar

			1 - State of Maryland / Registrar		artment of H rtificate of L			R	eg. No.	005	03144
i	Physici		1. Decedent's Name (First, Middle, Last) Stuart M. Fidler					Date of Deal Month Nuary	Day	Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o		inuary		County of Dea	06:25 A ^m
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	ath with the Marylan 23e or 28a-f show	Director	10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?					puntry?
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036	ours after deat irel', or Items ! Examinar mu	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1970-72	<u>.</u>	1□Yes 2⊠XNo	Specify:			1 5	Specify: Wh:	ite
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ylar	should be find Mental I marked of	ToE	Max Fidler					Baldwin			
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Baltimore,	permit. Pages Department of Importent: If it eny injury or once.		21. Signature of Funeral Service Licenses								Home, Inc.
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			30. Name and address of person who completed cause of deeth (Item 23a Michael M. Phillips, MD 2021 K.		Print)	Wachi	ingtor		20	1006	
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			T = For State Registrar	State of Maryland		artment of H			2005	03145
			Decedent's Name (First, Middle, Las	1)				2. Date of Death		3. Time of Death
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	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Y		hplace (State or Foreign untry)
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	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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က္	or Ita		1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 22 No	l'			Rican, etc.)	Black, White	e, etc.
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	To the Hospital or Al Within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my know ner: On the basis of examination and manner stated.	nedge, death on and/or inv	estigation, in my opi	e, date and place, a inion, death occurre	and due to the caus and at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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-	1		30. Name and address of person who co	ompleted cause of death (Item :	23a) (Type. F					
	/		30. Name and address of person who of PER FECTO C. VA	LARAD, M.D.	1716 H	ARFORD R	COAD Sul	OG FALL	STON M	021047
	Sta	te	31. Date filed (Month, Day, Year)	32. Medistrar's Signatu	ire					
	Registr	ar	FEB 0 2 20	U) Jakan A	J. 15%	and I				

			For State Registrar	State of N	Marylan		artment of rtificate o				giene Reg. No.	711115	03	146
	Physici		1. Decedent's Name (First, Middle, La.	st)						2. Date of Dea Month	ath Day	/ Year		of Death
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	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City, Town	Carroll				cince Ge		c
	Funeral		8517 Oglethorpe 5. Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under 1 Yea	ar If Under	24 Hrs.	8. Date of Birt (Month, Da				e or Foreign
	Director		579-50-1132 Usual Residence of Decedent	□ M 2 % DN=	88	Yrs.	Months Day	/s Hours	Min.	3/22/1	6		erson	
	ryland how		10a. State 10b. County	D (7		y, Town or Lo		_						City Limits
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n of	ding Ph h. After th funeral		27. Manner of Death 1 25 Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o		njury at Work?		28d. Describe I	now injur	ry occurred		
Sio	Attending it death.	catio	2 Accident investigation					I∐Yes 2□	_		<u> </u>		10	
Division	f or Attend after death Director: / i in by the f	Certification;	3 Suicide 6 Could not 8 4 Homicide determined	286. Place of	Injury - At h , etc. <i>(Speci</i>		reet, factory, offi	ce		City or To		nd Number or Rui e)	rai Houte N	um <i>ber,</i>
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	(Check only 2 Medicel Exa	nysicien: To the be miner: On the basi and manner	s of examina									e(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner	Stateu.	- 1 -	29c. Lic	ense number			29d, Dat	te signed (Month	, Day, Year	-)
	To To) He	Lev	1600	de	S	1000	515			1/19/	1	
11/	VII		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type	Print	U				11.110	, ,	
4	7		Hector K. Coll					.W.,# 1	500,	Washing	ton.	D.C. 20	010	
	St Regist	ate rar	31. Date filed (Month, Day, Yar) 20		istrar's Sign		andly)	•						

			1 - For State Registrar	State of Maryla			of Health and of Death		giene 005	03147
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Yea	3. Time of Death 1 4 4 0 M
	/Medic	cal	4a. Facility Name (If not institution, give	. Geraly		4h City Tow	vn, or Location of Dea		8 , 2005 4c. County of De	
	Examir	iei	Shady Grove H	•			Rockvill			gomery
	Funeral Director				rs. last birthday) O yrs.	If Under 1 Y Months Da	ear If Under 24 Hr ays Hours Mir	. (Month, Da		Birthplace (State or Foreign Country) New York
	/land low		Usual Residence of Decedent 10a. State 10b. County		City, Town or Le					10d. Inside City Limits
	e Man Re-f sh Liffed	ctor	Md. Montgo	mery		Rocky	ville			1 Yes 2 □ No
	s 1 and 2 should be filled within 72 hours after death with the Maryland f Health and Mental Hygene. I then 27 Is marked other then. Insturel; or Items 23e or 28e-f show other treumetic event, the Marical Examinational termolified at	Funeral Director	10e. Street and Number 9537- Veirs D	rive		10f. Zip Coo	2085		10g. Citizen of What US	Country? SA
	er dea	uner		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14. Race - Ar Black, W	merican Indian, hite, etc.
336	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW	11	1□Yes 🏋	No Specify:		Specify:	White
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Or	ccupation one during most of w	odkina	16b. Kind of Busines	ss/Industry
121	within ine.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)	Juliy	D 6	
d 2	filed with Hygiene. Ither ther		1 2		<u> </u>	S.Govt		me (First, Middle,	Defense	Mapping
Maryland	2 should be f and Mental H is marked of eumetic eve	To Be	George Geraly		-1		Dzia	dzan Moi	rjikian	
	es 1 and 2 st of Health and item 27 is r other treur		19a. Informant's Name/Relationship (Ty, Felice Mancarus	o- Nephew	15-	Black	perry Way	y, Hopewe	or, City or Town, State ell Junct	tion 12533
Baltimore,	0 0 == =		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)		tropol	matory or other	place)	Date y=1/19/(20c. Location - City of D5-Alexai	or Town, State
Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service License	99	25	2. Name and Ad Hys 651	ddress of Facility Song Co.	Inc	Wash.,DO	7
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de	eath. Do not en	ter the mode of	dying, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	aspirati			nonia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
	ocuted nd transit	Examiner	that initiated events	·						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a cons	equence of):					
687	flicate p physics ts the	edical								
Вох	h certific ending p	M/W	230. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregna	2004		23d. Date of d	elivery
О. В	at the death by the atter tached for u	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time o 9 Unknown		Other (specify			Month	Day Year
s, P.	s that t ned by e detai	by Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ords	w requires that been signed b should be deta							1 🗆 Y	es Mo 3 1	Probably 4 Unknown
Vital Record	as b	ompleted				·		24a. Was a	sy prior to	autopsy findings available completion of cause of
alF	10 11	0	05.14(2€ No 1 1 Ye	
<u> </u>	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: Impatient 2	☐ ER/Outpatier	nt 3 DOA	Othor	ath (Check only or		
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	or Attending after death. Director: After in by the fune	ertiflcatlon;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At	home, farm, str			28f. Location (S	treet and Number or I	Rural Route Number,
	9 S = 0	O		building, etc. (Spe		D. Coorres d et th		City or Town		
	the Hos in 24 h the Fur ipletely	Aedical	one)	ner: On the basis of exami and manner stated.	nation and/or in	vestigation, in n	ny opinion, death occ	urred at the time, d	date and place, and du	ue to the cause(s)
6	P ₹ 0 55	Σ	29b. Signature and title of certifier	J. Misty	MD		sense number 59738		January	i 18, 2005
	De		30. Name and address of person who co Alicia T, Mis		em 23a) (Type, Me.d.	Print)	Center D	rive Ro	chuille,	no 20850
E	Sta Registr		JAN 2 1 2005	32. Registrar's Sig						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Carmelo 1610 M Gugliotta 10,2005 JANUA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chever (If Under 1 Year If Under 24 Hrs. 1405 6 corge's Tal 6 ever's 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**⊠**M 2□F 233-30-9236 81 Director 10, West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? tree must be n 6131 Naval Avenue 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Item: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Item 1 Never Married 2 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Year or Dates White ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Operating Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cosimo Gualiotta Santa Guqliotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Gugliotta (Wife) 6131 Naval Avenue, Lanham MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Nother (Specify) Entomoment Resurrection Cemetery 1/14/2005 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Arnapolis Road, Lanham MD 20706 Par . Enter the disease, or connectations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, synck, or heart failure. List our one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sub dural Hemoir has **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certiticate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₽Yes 2□ No 2 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 12 N M 28d. Describe how injury occurred 27. Manner of Death Certification: Atter t hule halking outside 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident home 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 3 NAVIL Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Home LANGAM within 24 hours a may land 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dro 1405 32. Regetrar's Signature 31. Date filed (Manth 2005

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Henry L. Goebel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Aug 21, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12XM 2□F Months Virginia 548-38-5305 86 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant. Its Modical Examinar must be notified at 1⊠Yes 2□No Director Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8603 Fremont Street 20784 USA 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "natural", or Itams 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married ww/II 1 ☐ Yes 2 No Specify Ā Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Curtis H. Goebel Virginia Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a tant: If itam 27 Is Vivienne O. Goebel (Wife) 8603 Fremont Street, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory 1/21/2005 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and the burial-transit arole ongo resulting in death) Last the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death Year 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 **N**O 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funaral Diractor: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours af To the Funaral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 22111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANHAM MD 30706 M.D. 8100 GOOD LUCK RUAD THOMAS KO 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 1 2005 Registrar

Please Type	or Print in E	Black Indelible Ink.	Ensure All Copies Are Lo	egible
_				

State of Maryland / Department of Health and Mental Hygien 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SR. Year 6ERMON 10SEPH NTLES 0735 AM JANUARY 17 US /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 27 9. Birthplace (State or Foreign **Funeral** ^Y1920 1**⊠**M 2□F Director 217 07 2228 84 Vre Aug. Pennsýlvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Md. Frederick Mt. Airy Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 4170 Walnutwood Court 21771 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify 3 □ Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury of other traumatic event, tra Medical Exa any injury of other traumatic event, tra Medical Exa 2018. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Telephone Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Phoebus Elsie William Speake Germon Irene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 4170 Walnutwood Court, Mt. Airy, Md. Audrev L. Germon / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Cemetery 1/20/05 Rockville, Md. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home
P. 0. Box 5038, Laytonsville, Md. 21. Signature of Funeral Service License pure 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician UNG CANCER munTh s /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed CAD Yars Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery lor , 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 💆 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 KNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier, 641 000 62234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROLEVILLE MANISH Medical AGRANAC 9707 Center anve Suite 300 31. Date filed (Month, Day, Year) State parte 19 2005 JAN Registrar

			1 - State Registrar	of Maryland / Depa	rtificate of Death	Reg.	711115	03151
	D		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Catherine Ann	Gordon		January	18 2005	6:40 P M
	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Death	
			7084 Catalpa Road		Frederick		Freder	ick
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
D.	Director		215-30-2610	70 Yrs.		February 2	2,1934 Mar	yĺand
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	position			10d. Inside City Limits
	sho	2						1 ☐ Yes 2 ☐No
	Ba-f	Director	Maryland Frederick	Frederic				
	vith t		10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
	s 23	Funeral	7084 Catalpa Road		21703		United St	
	er de	n n	Armed	Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	, or		TYPS,	es 2∭Myo Give or Dates:	1 ☐ Yes 2 🛣 🗓 No Specify:		Specify: W	hite
8	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show the Madical Examinar must be indiffied at	Completed by	15. Decedent's Education		dent's Usual Occupation	16	o. Kind of Business/Ir	dueto
15	C * 38	olet	(Specify only highest grade complete	(Give	kind of work done during most of work DO NOT use retired)	ing	5. Tana 57 Basinoss/ii	
12	within iene.	E o	Elementary/Secondary (0-12) Colleg	e (1-4or 5+) Home	emaker	0	wn Home	
0	Hygur than the	a	17. Father's Name (First, Middle, Last)	, 110,,,,		e (First, Middle, Mai		
an	a c ta	0 0	Benjamin Siford		Elizabet	h I one		
Maryland 21215-0036	is 1 and 2 should be of Health and Mental itam 27 is marked of other traumatic avaints.	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Run		ity or Town, State, Zij	Code)
	and 2 ealth a n 27 is		Kenneth Williams/ Son	12 S.	Pendleton Court/	Frederick	Maruland	21703
ē,	s 1 an I Heal Itam 2 other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Location - City or To	
Baltimore,		1	1 ☐ Burial 2 ∰ remation 3 ☐ Removat fr `4 ☐ Donation 5 ☐ Other (Specify) _	om State	matory or other place)	m 2005 B	/1 1 1 14	4 1
量	it. F		21. Signature of Fureral Service Library		Cremetory, Inc. Jan. 2. Name and Address of Facility	touffer F	uneral Hor	yland D A
Ba	permit. Page Department of Important: If any njury or ance.			V/				
100		,	23a Part1 Enter the disease, or complications the shock, or hear failure. List only one cause	at caused the death. Do not ent	1621 Opossumtown P	TKE/FTEGE or respiratory arrest.	rick Mary	Approximate
Ш	*		shock, or head failure. List only one cause of Immediate Cause (Final	in extension.	, , , , , , , , , , , , , , , , , , ,	,,		Interval Between Onset and Death
	Pnysician /Medical	i i	disease or condition	ASC VD				5 4RS
	Examiner		Due	to (or as a consequence of): HYPENTE	ciani			5 425
		-a	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of):	0.21010			1 11-7
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury					
	and al-tra	ха	that initiated events c.	to (or as a consequence of):				
68760,	icate be executed physician and s the burial-transit	alE						
587		edical	d					
Box (teath certifica attending ph		IF FEMALE: 23c. If yes, 23c. Was decedent pregnant	outcome of pregnancy			23d. Date of delive	erv
B	atter	clar	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
o.	at the de by the a tached	Physician/M		known				
٥	the ad		Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
Vital Records,	signe signe	d by				1 ☐ Yes	2 No 3 Frot	pably 4 Unknown
Ö	w require been si should I	ompleted				24a. Was an	24h Word auto	nneu fiedinge evellable
3e	9 4 9	ш				autopsy	prior to co	ppsy findings available impletion of cause of
a		O				1 ☐ Yes 2 🗗		2 No
V:t	certific rector,	Be	25. Was case referred to medical examiner?		Other	(Check only one)		
of	Physician: this certificant	7	1 165 2 100	☐ Inpatient 2 ☐ ER/Outpatien	11 3 DOA 4 Nursing Ho	me 5 A Residence 28d. Describe how i		(y)
n	fter	ion	1 ■ Natural 5 Pending (A	fonth, Day Year) Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	200. Describe now i	njury occurred	
Si	ag ag	ical	3 Suicide 6 Could not be	ace of Injury - At home, farm, str		28f Location /Stree	t and Number or Rura	al Route Number
	de de		4 Homicide determined by	ilding, etc. (Specify)	eet, lactory, office	City or Town, S	tate)	arriodio reamber,
<u>></u>	or Attending after death. Diractor: After in by the fune	ir				and due to the cours	0/a) and manner as a	
Division	pital or Attendi burs after death. aral Diractor: A filled in by the fu	Certification:	202 Cortifier 18 Cortifuing Physician: To	the best of my knowledge, death	h accurred at the time, date and place			Amb I
Div	Mospital or Atte 24 hours after de Nours after de Funaral Diracto etely filled in by th		(Check only 2 Medical Examiner: On the	e basis of examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	tated. o the cause(s)
Div	o the Hospital or Atterition 24 hours after de otha Funaral Diracto ompletely filled in by the	Medical Certi	(Check only 2 Medical Examiner: On the	the best of my knowledge, deatle basis of examination and/or in lanner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
Div		edical	(Check only one) 2 Medical Examiner: On the and not significant title of certifier	e basis of examination and/or in lanner stated.	vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to Date signed (Month,	Day, Year)
Div	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	29b. Signature and title of certifier 70 - 3191	e basis of examination and/or in lanner stated.	29c. License number	ed at the time, date	and place, and due to Date signed (Month,	Day, Year)
Div	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Total of	edical	2 Medical Examiner: On the and n 29b. Signature and title of certifier	e basis of examination and/or in lanner statt d.	vestigation, in my opinion, death occurred 29c. License number D - 3191	29d.	and place, and due to Date signed (Month,	Day, Year)
Div	To the Hospital or Atte within 24 hours after de within 24 hours after de To the Funaral Direct completely filled in by the State of th	Medical	29b. Signature and title of certifier D - 3 9 30. Name and address of person who completed of the complete of the comple	e basis of examination and/or in lanner statt d.	29c. License number	29d.	and place, and due to Date signed (Month,	Day, Year)

			1 - For State Registrar		State of I	Marylan	nd / Depa <i>Cei</i>	artment of F rtificate of I	lealth ar D <i>eath</i>	nd Mental H	ygiene Reg. No		03152
	Physici	on.	1. Decedent's Name	(First, Middle, Las	t)					2. Date of I	Death		3. Time of Death
	/Medic			M. GLIST						JANUA	RY T	t, 2005	10:27A. м
	Examin	er	4a. Facility Name (If 9200 VER	not institution, give		er)		4b. City, Town, or Laplata	Location of I	Death		County of Death	
	Funeral		5. Social Security No		ox 7	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year)	9. Birth	place (State or Foreign
L.	Director		217-17-092 Usual Residence of	<u> </u>	X	29	Yrs.			Sept			**
	aryland show		10a. State	10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	Man 9-f sh	ctor	Maryland	Charles			La Pl	ata					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Num					10f. Zip Code			10g. Cit	izen of What Cour	ntry?
	ath w		9200 Ver	million C				20646				USA	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Itams 23a or 28e-f show avant. It a Medical Evarinar man terrofiled at	by Funeral	11. Marital Status 1 X Never Marrie 3 Widowed	ed 2 Married	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ₹No	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🏋 No	ispanic Origin In, Mexican, F Specify:	? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify: Whi	etc.
5-0	natu Jical	Completed	(Speci	15. Decedent's Ed	ucation de co <i>mpleted)</i>		16a. Deced (Give	tent's Usual Occup kind of work done o OO NOT use retired	ation during most of	working	16b. Ki	ind of Business/In	dustry
121	within lene. than	dmo	Elementary/Secon	ndary (0-12)	College (1-4c	r 5+)	Plumb)	·	Co	nstructo	n
d 2	filed with Hygiene. other thau		17. Father's Name (First, Middle, Last)			Fiduc	ET	18. Mother's	Name (First, Midd			41
lan	should be filed id Mental Hygi marked other matic avant,	To Be	Vincent (71iata						Shipe G1			
Maryland	2 should and Meni is marker aumatic	-	19a. Informant's Na		урө, Print)		19b. Mailin	g Address (Street a				r Town, State, Zip	Code)
	rtr		Helen L. (ister)			alleywood		Millersv	ille,	MD 2110	8
Baltimore,	Pages 1 all nent of Hearn of Hearn int: If itam iny or otha		20a. Method of Disp 1 ☑ Burial _2 ☐		Removal from Sta	20b. P	Place of Dispo emetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Lo	cation - City or To	own, State
Iţim	permit. Pag Department Importent: I any injury o		` 4 ☐ Donation 21. Signatu e J Fur	☐ Cremation 3 ☐ 5 ☐ Other (Specify		St.		es Cem.		-22-05	Gly	mont, Ma	ryland
Ba	permit. Pages Department of Importent: If i any injury or once.		boh	nHE	beur	00173	44	Name and Addres	Pls. I	Eberwein	Pls.		
			1//			ed the death line.	h. Do not ente	or the mode of dying	g, such as car	diac or respiratory	arrest.		Approximate Interval Between
	Physician /Medical		Immediate Cause (fi disease or condition resulting in death)	Final Colo	acts hot	run a	vounds	(z) to h	rad a	ucl muiti	ple Cu	itting	Onset and Death
	Examiner		,		Due to (Tra	is a consequ	uence of):				W	oungs	
		Jer	if any, leading to improve the cause. Enter Under Cause (Disease or in	mediate	Due to (or a	is a consequ	uence of):			-13W			
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events		c								
90,	oe execian a		resulting in death) L	ast	Due to (or a	is a consequ	uence of):						
68760,	physics the t	edical			d								
Box 6	death certific e attending p ed for use as	hysician/Me	IF FEMALE: 23b. Was decedent in the past 12 r	pregnant	23c. If yes, outcom	2 Fetal	death 3	Ectopic pregnancy			2	23d. Date of delive	ory Day Year
P.O.	0 0	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown]No	4⊡Pregnant 9⊡Unknown	at time of de	eath 5L	Other (specify)					
	res that signed b be deta	by Pt	Part II. Other signific	cant conditions co	ntributing to death	but not resu	ulting in the un	iderlying cause give	n in Part I.	23e. Did	l tobacco u	se contribute to th	e cause of death?
ırds	w require been sig should b									_ 1 🗆	Yes 2	No 3□Prob	ably 4 DUnknown
Division of Vital Records,	has has	Completed									s an opsy formed?	prior to con	psy findings available inpletion of cause of
tal	ician: Th certificate rector, pag	e Co	25. Was case referre	ed to medical					OR Disease	1 Yes	2 🗆 No	death? 1X Yes	2 No
Ž	d is	To B	examiner? 1 X Yes 2 ☐ N	No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatient	3 DOA Othe		ng Home 5 ☐ Res		X Other (Specify	SCENE
0 0	ng Ph fter th neral		27. Manner of Death	5 Pending	28a. Date of In	jury Jay Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury	occurred cut	CIL
sio	tandi eath. tor: A the fu	catle	2 Accident	investigation	Found 1/1	-	halugar	(M 1□)	es 2 No				/
Ο	or At after of Dirac in by	Certification:	4 Homicide	determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i> y	1)	et, factory, office		City or To	own, State)	Number or Rura	
_	spitel lours naral filled		29a. Certifier	1☐ Certifying Phy	sicien: To the bes	at of my know	At C	occurred at the tim	e date and n	ace, and due to the	e callee/e/	Court, Lapi	ated
	To tha Hospitel or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	(Check only one)	2X Medical Exem	ner: On the basis and manner:	of examinat	tion and/or inv	estigation, in my op	inion, death o	occurred at the time	, date and	place, and due to	the cause(s)
	To the within To the comp	Me	29b. Signature and t		, ,			29c. License	number		29d. Date	signed (Month, L	Day, Year)
)			La	livel	lal A	li"		0.0	C.M.E.		JANUA	RY 17,20	05
À	В		30. Name and addre	ss of person who c	ALI			111 PEN	N STRE	ET BALTIN	ORE N	MARYLAND	21201
	Sta Registra		31. Date filed (Month	JAN 2 0 2	32. R dis	trar's Signat	ture	backs					

			1 - For Stete Registrer	State of Maryland / D			Mental Hyg	iene _{2 nn5}	03153
			Decedent's Name (First, Middle, Last)			Or Boatin	2. Date of Deat	g. No.	3. Time of Death
Н	Physici /Medic		John Stanley Hewi	t, Sr.			January	20, 2005	7:25 A.M
1	Examin		4a. Facility Name (If not institution, give str		4b. City, To	own, or Location of Death		4c. County of Deat	
			Calvert Memorial Ho			ce Frederick	Ī	Calvert	
	Funeral Director		5. Social Security Number 216-40-8253 Usual Residence of Decedent	7. Age (In yrs. last bin	thday) If Under 1 Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, January	9. Bin 1, 1934 Ma	hplace (State or Foreign puntry) aryland
	yland yow		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	a-1st	ctor	Maryland St. Mary	s Avenu	ie				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip C		10	g. Citizen of What Co	ountry?
	s 23a	rai	38215 Palmer Road	Was Bassadan Guaria II G		0609		USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel," or Items 23e or 28e-f show sumatic event, the Modical Exaculturer mast tennetified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 M/No If Yes, Give Year or Dates:	If Yes, specify	nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: White	e, etc.
5-0036	2 hou	ted	15. Decedent's Educa	tion 16a.	Decedent's Usual	Occupation	. 1	16b. Kind of Business/	
21218	thin 7 e. en "n Mod	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	done during most of work retired)	ang		
21	led wi ygien yer th	Con	8	Mai	ntenance			County Gove	ernment
Maryland	o = 0 >	Ве	17. Father's Name (First, Middle, Last) Hiram Hewitt				e (First, Middle, M	faiden Surname)	
Ĕ	should be tand Mental I s marked of umatic eve	^o	19a. Informant's Name/Relationship (Type	Print) 10h	Mailing Address (Madeline Street and Number or Rur		City of Town Chair	E- O- d-1
<u>∞</u>	and 2 s salth an n 27 is i		Shirley marie Hewitt			er Road. Ave		20609	up Code)
ē,	1a Hear Em		20a. Method of Disposition		Disposition (Name	of er place) Janua	Date 2	Oc. Location - City or	Town, State
Baltimore,	Pages nent of nnt: If its iry or o		1 X Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)		y, crematory or othe Memoria	l Gard 25, 2	-	eonardtown	ı. Md
alti	permit. Pages Department of Importent: If it any injury or o	1	21. Sign yurr of Funeral Service Licens		7	Address of Facility Ley-Gardiner	_		
m	P P E E E		Thechard Kevra Ho	Erden 1		270 Leonar			
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do r	not enter the mode	of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Chronic Obstruc					Onset and Death Years
	/Medical Examiner		resulting in death)	Due to (or as a consequence of		DISCASE			Tears
	LAGITITIES	L	Sequentially list conditions, b.		-0				
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate Fig. 11. 3. 3. in Cause (Disease or injury	Due to (or as a consequence of	of):				
	xecui n and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence of	of):				
8760	te be executed ysician and e burial-transit	icai							
89	8 E E		d.						
Box	eath certific attending p	Physician/Med	23b. Was decedent pregnant	If yes, outcome of pregnancy	3 □Ectopic preg	Danay		23d. Date of deli	very
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (spec			Month	Day Year
0	at the de d by the etached	Phy	9 🗆 Unknown						
Ś,	res tha signed be det	by	Part II. Other significant conditions contr Diabetes	buting to death but not resulting in	the underlying cau	se given in Part I.		acco use contribute to	
ecords,	law requires that the as been signed by th 2 should be detache	eted					125 195	s 2 □ No 3 □ Pro	bbably 4 □Unknown
Hec	o - o	ompleted	Right Heart Fail	ire			24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
	n: The licate har, page	O						ed? death? XNo 1☐Yes	⊉ □ No
Vital	Physicien: this certific	o Be	25. Was case referred to medical examiner?	spital:			h (Check only one		
	Phys or this oral di	\vdash	1 ☐ Yes 2 🙀 No 27. Manner of Death	1 X Inpatient 2 ☐ ER/Out 28a. Date of Injury (Month, Day Year) 28b. T		Other: 4 Nursing Ho Injury at Work?	me 5 ☐ Resider 28d. Describe hov	nce 6 ∐Other <i>(Spec</i> vinjury occurred	ify)
0	Attending I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Ir	njury M	Work? 1 ☐ Yes 2 ☐ No			
Division	of or Attendi after death. I Director: A d in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, o	office		et and Number or Ru	ral Route Number,
5	itel or rs afte el Dir	Cert		banang, atc. (opeany)			City or Town,	Jiaiti)	
	To the Hospitel within 24 hours a To the Funerel C completely filled	edical	29a. Certifier (Check only one) 1 ★ Certifying Physic 2 ★ Medicel Examine	ien: To the best of my knowledge, r: On the basis of examination and and manner stated.	, death occurred at Vor investigation, in	the time, date and place, my opinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	α	29c. L	icense number	29	d. Date signed (Month	Day, Year)
			1 tan 01		D4	40370		1/20/05	
8	M		30. Name and address of person who com		,	2 11 010 =		1 9 1	20672
			Peter Wisniewski, N 31. Date filed (Month, Day, Year)	I.D. 100 Hospita 32. Registrar's Signature	I Koad.	sulte 310 Pr	ince Fre	aerick, Md	20678
	Sta Registr		JAN 2. 5 201		Partie				

			For	State of Maryla		artment of H		and Mental	. 0	2005	00151
			Registrar		Ce	runcate or i	Deam	2. Date	Reg. No	<u> </u>	U3/54
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Monti	n Da	•	3. Time of Death
	/Medic	al	Lois Merle	Hajmosi		45 Ob. T	. 1	Janu			11:15 A [™]
4	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		of Death		. County of Death	
			1832 Crofton Par 5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	fton If Under:	24 Hrs. 8. Date		Anne Aru	
	Funeral Director			M 2⊈F 88		Months Days	Hours	Min. (Mont	h, Day, Year,	1016 Por	nplace (State or Foreign untry) nnsylvania
			Usual Residence of Decedent					Harc	11 24,	1710 161	msyrvania
	ylanc		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mar 9-f sl	tor	MD Anne Arun	ide1		Crofton					1y Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cor	untry?
	ous after death with the Marylar rai', or items 23a or 28e-f show Examiner must be notified at	eral D	1832 Crofton Pa	rkway		21	1114			U.S.A	2
	ems ems	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	gin? (Specify Yes	or No-	14. Race - Amer Black, White	ican Indian,
9	or it	/ Fun	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			hite
8	72 hours after death with the Maryland reatural; or Items 23e or 28e-1 show olded Examiner must be notified at	d by	3 🙀 Widowed 4 □ Divorced	Year or Dates:							
21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mosi	t of working	16b. K	(ind of Business/l	ndustry
12	d within 72 jiene. ir than "nai	E D	Elementary/Secondary (0-12)	College (1-4or 5+)			,				- 4-
7			17. Father's Name (First, Middle, Last)		Stat	istical (er's Name (First, M		Governmen	וב
and	ed ta	Be	Thomas O'Donne	.11						, Garrierro,	
Maryland	d 2 should be the and Mental I is marked o treumatic eve	ပ္	19a. Informant's Name/Relationship (Type		19h Maili	ng Address (Street	and Numbe	Ella Br		or Tourn State 7	în Code)
Ma	ロモトラ										p 000e)
-	5 4 5		Aileen Hajmosi - 20a. Method of Disposition		Place of Dispo	2 Croftor sition (Name of		kway Cro		D 21114 ocation - City or 1	Fown, State
Baltimore,	permit. Pages 1 a Department of He Importent: If Item any injury or othe		1 ☐ Burial 2 🗷 Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or other plac					
틒	it. Partment		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service tidense			oln Crema				entwood,	
Bal	Department		21. Signature of Furieral Service didense			2. Name and Addres					
			23a. Part1. Enter the disease, or complic	nations that caused the de-		401 Blade				ood MD Zi	0/22 Approximate
			shock, or heart failure. List only on	e cause on each line.	* •	ter the mode or dyin	~		ory arrest,		Interval Between Onset and Death
	Physician /Medical	V6 1	Immediate Cause (Final disease or condition resulting in death)	AITZH	EIMP	ns a	156	ase			4 years
	Examiner			Due to (or as a conse	equence of):						10.8
		er	Sequentially list conditions, b	Due to (or as a conse	equence off:						
	led sit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (01 40 40 001100	14401100 017.						
	and and	Examin	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):						
8760,	the death certificate be executed the attending physician and iched for use as the burial-transit										
687	icate phys s the	edicai	a								
	eath certific attending pi	/We	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregi	nancy					23d. Date of deliv	verv
Вох	atter I for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fei 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	,			Month	Day Year
o.	by the tached	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
Φ.	that ned b		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	. 23e.	Did tobacco	use contribute to	the cause of death?
ds,	uries ngn ld be	d by							1 ☐ Yes 2	No 3□Pro	bably 4 Unknown
Records,	The law requires that ite has been signed b bage 2 should be deta	Completed						24a.	Was an	24b. Were aut	topsy findings available
Re	The farate has	E C							autopsy performed?	prior to c death?	ompletion of cause of
Vital		Ö	25. Was case referred to medical				OG Place	of Death (Check		1 L Yes	2 No
⋚	Ser Cer	o B	examiner?	ospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 DOA Oth		rsing Home 5		6 DOther (Spec	if()
o			27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at		ibe how inju		ny)
Division	ding I th. : After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wori M 1 □	k? Yes 2. □	No			
/isi	after death.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st	reet, factory, office					ral Route Number,
á	al or	Certification;	4 Homicide	building, etc. (Spec	city)			City	or Town, State	9)	
	To the Hospital or Attending within 24 hours after death. , the Funeral Cirector: Afte c pletely filled in by the fune			ician: To the best of my kr							
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, dea	th occurred at the	time, date an	d place, and due	to the cause(s)
	To the within 2 the control the let	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (Month	, Day, Year)
	(III)		122	ex mo)	120	029	1571	0	1/21/	2005
	V. O		50. Iguno site against a gamail who co	muleta cause of death (Ite	em 23a) (Type,	Print)	1	the determinant		1	0
	A.C.		Paul Berez	mD 16	55. (Print) Croft	n C	31vd	STP	101 C1	ofton mp
	Sta		31. Date filed (Menth Pangear)	32. Recorrar's Si	The same						
	Registr	ar	JAIV	, ,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) U 8 Time of Death 2. Date of Death **Physician** Jan. 13, 2005 Year Bernice G. Halverson 11:41 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Hospital 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 23, 1917

8. Birthplace (State or Fig. Country)
Minnesota **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □X 468-07-2881 87 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Micdigal Examiner must be notified at Md. Montgomery Rockville Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701-Veirs Drive 20850 USA "natural", or items 23a filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2 X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AT Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othn any injury or other traumatic event, 2002s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter Kenerud Maria Rasmussen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Halverson- Son 18 Monroe Street, Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory-1/14/05-Alexandria, Va. `4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hysong Co., Inc. 23a. Part1. Enter the disease, shock, or heart failure. L wan that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death e on each line **Physician** disease or condition Sepsis Days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 XNo 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 🛣 No 1X Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Xatural 5 Pending vithin 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Fune To ths } 29b Signature and title of certif 29c. License numbe 29d. Date signed (Month, Day, Year) Jan.14,2005 130061681 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Robert Kirkcaldy -9901 - Medical Center Dr., Rockville, Md. 20850

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

			For State Registrar	State of M	laryland / Depa	artment of H			giene	05 03156
			1. Decedent's Name (First, Mide	dle, Last)				2. Date of De	eath	3. Time of Death
	Physici /Medi		Jacqueline	Louise	Hedrick			Janua	Day 29. á	Year 2005 5:45 PM
	Examir		4a. Facility Name (If not institution	on, give street and number)	4b. City, Town, or	Location of Death		4c. County	
			Memorial	Hospit	al	Cumb	erland	4	Alle	gary
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th V Vaar)	9. Birthplace (State or Foreign
ш	Director		214-48-3079	1□M 2▼F	57 Yrs.	WOTHIS Days	Hours Mill.	8. Date of Bir (Month, Da NOV 3,	1947	Country
	pu 🖈		Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town or Lo					
	aryla	7		gany		perland				10d. Inside City Limits
	Ba-f	Director								1X Yes 2 No
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show cleat Examiner must be notified at	ä	10e. Street and Number			10f. Zip Code	14500		10g. Citizen of	
	s 236	Funeral	824 Shades La				21502		US	
	er de Item	nue	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Decedent Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S) n, Mexican, Puert	pecify Yes or No p Rican, etc.)	o- 14. Rad Blad	ce - American Indian, ck, White, etc.
36	rs aft		1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	No	1□ Yes 2 No	Specify:		Specif	⁵ white
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12	filed within Hygiene. Ither than "	шо	Elementary/Secondary (0-12)	College (1-4or	5+1	grapher	,		Allegany	y Co Rd Dept.
D	Hygie other ant, II	Be C	17. Father's Name (First, Middle	, Last)	12.000	,	18. Mother's Nam			
an	ould be Mental arked o	To B	Oscar J. Lew	vis, Sr.			Dorothy	L. (Lea	ase) Lew	ris
Maryland	2 should land and Meni	-	19a. Informant's Name/Relation		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or Town.	State, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic evant. Ite Mcdical Examiner must be notified at		Larry Hedrick	husb	and 824	ng Address <i>(Street a</i> Shades La	ane	Cumb	perland	MD 21502
3altimore,	of Hea		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	al I	Date	20c. Location -	- City or Town, State
Ë			1 ØBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sunset Men	norial Park	7) 	2/3/2005	Cumbe	erland MD
alt:	nit. artm orta inju		21. Sign there of Funeral Service		. 22	Name and Address	sret Facility	DA		
m	Deparenti Importany ir		/ Jam	A Don	(1)		inia Avenue		land MD	21502
	=		23a. Part1. Enter the disease, of	or complications that cause	d the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate
	ALC: U		Immediate Cause (Final	st only one cause on each I	ine.	¥				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Ceret	a consequence of):	morrh	age			Zalnys
	Examiner				brovascu	Jar A	coider	+		Iweek
		e	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence or).	ciat >i	coraci	11		INECK
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ć	exec in an ial-tr	Еха	resulting in death) Last		a consequence of):					
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9	tifical g phy as th	edi			1		4			
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7e			23d. Dat	te of delivery
	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		Ectopic pregnancy Other (specify)			Moi	nth Day Year
Ö.	by the detached	hys	9 Unknown	9□ Unknown						
٦,	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	ру Р	Part II, Other significant condit				n in Part I.	23e. Did to	obacco use conti	ribute to the cause of death?
Ë	quire an sig	ed	Kenal Cell	Carcinon	na, Core	nary		1 🗆 1	res 2 🕱 No	3 ☐ Probably 4 ☐ Unknown
00	law requas been 2 should	Completed	Artery D.	sease 5				24a. Was	an 24b. V	Were autopsy findings available
R	The la	E O	1-2		11 0.10				rmed? , c	prior to completion of cause of death?
Vital Records,		a	25. Was case referred to medical	al			26. Place of Deat			1 ☐ Yes 2 ☐ No
\geq	S S	0	examiner? 1 □ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/Outpatien	t 3 DOA Othe	_		dence 6 Othe	ar (Snacifu)
ı of		n: T	27. Manner of Death	28a. Date of Inju	ary 28b. Time of	28c. Injury Work			now injury occurr	
0	Attending F death. ctor: After y the funer	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	tigation (World), Da	ly Year) Injury		es 2□No			
Division	il or Attending after death. I Diractor: After d in by the fune	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 28e. Place of In	jury - At home, farm, stre tc. (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number	er or Rural Route Number,
	rs afti al Dii	Certification:		Juliung, et	(oposity)			July OF TOW	, Jidle/	
	Hospital	cai	29a. Certifier 1 Certifyi (Check only 2 Medice	ing Physician: To the best I Examiner: On the basis of	of my knowledge, death	occurred at the time	e, date and place,	and due to the	cause(s) and ma	nner as stated.
	the the the	ledical	0.707	and manner st	ated.			ied at the time, t	uate and place, a	und due to the cause(s)
	Vita Son To To	Σ	29b. Signature and title of certific	er 1	1,	29c. License	number		29d. Date signed	(Month, Day, Year)
			Valaher	+ / como		D586	₂ 55		1/30,	105
	1		30. Name and address of person	who completed cause of	_	Print)				
	6		Sahabat Na	wab MD.	P.O. BOX 2	65 Gr	antsvill	e Ma	ryland	1 21536
94	Sta	-	31. Date filed (Month, Day, Year FEB 0 3 2005	200	rar's Signature					
	Registr	ar	1 50 69 5000	Mound 1	Je Boortes					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Year Physician GEORGE IGNATIUS HILL 19 Jan 2005 10:20A /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical La Placa

If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year)

JUNE 9, 16 La Plata Charles 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Months Days 217-60-9429 Director 66 1938 MARYLAND Usuel Residence of Decedent 10a, Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f shov traumatic event, the Medical Examiner must be notified at ¶ Yes 2 □ No Funeral Director MD CHARLES NEWBURG 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 230 11200 ACKER ROAD 20664 UNITED STATES Hems ? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status e filed within 72 hours after al Hygiene. other than "natural", or ite 1 Never Married 2 Married Haltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rade completed Elementary/Secondary (0-12) College (1-4or 5+) FARMER FARMING 3 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Pagas 1 and 2 should be filk mant of Health and Mental Hi ant: If Itam 27 is marked oth HARRY HILL JULIA CHISLEY HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) VERNON CHISLEY/COUSIN 6001 WALNUT STREET, TEMPLE HILLS, MD 20748 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If Its any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HOLY CHOST CHURCH CEMETERY 1/27/05 ISSUE, MARYLAND Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. DRUSER LYDIA C. THORNTON JOHNSON 3435 LIVINGSTON ROAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attanding physician and for usa as the bunal-transit or Attending Physician: The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. quence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ Be Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 1 Yes 2 DNG A or Atterning a standard of the conflicate of Director. After this cartificate of the funeral director, pr 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D-20629 30. Whene end address of person who completed cause of deeth (Item 23e) (Type, Print) 11345 Pembrooke Square Suite 103 Waldorf, MD 20603 George $H \searrow$ Wathen, MD 31. Dete filed (Month, Day, Year) 32. Redistrer's Signature State JAN 2 1 2005 Registrar

			1 - For Stete Registrar		State		nd / Dep	partment of H	dealth a	and M	•		_	03150
			Registrar 1. Decedent's Name (First	at Mindella I an	-41		Ce	ertificate of	Death			Reg. No.	.000	00100
	Physici	an					T1616	TD			2. Date of Dea Month	Day		3. Time of Death
	/Medio		ALDEN 4a. Facility Name (If not in	ELOI			IMUS,	JR . 4b. City, Town, o	s Location	of Death	January		2005	12:00 p ^M
	Examir	ier	Washington			,		Takoma I		or Death			County of Death	
	Funeral		5. Social Security Number				s. last birthda) If Under 1 Year	If Under	24 Hrs.	8. Date of Birti (Month, Day	h M	ontgome:	
	Director		219.01.3348	1	⊠ M 2□ F	8.	5 Yrs.	Months Days	Hours	Min.	Nov. 29	Year)	919 Wash	pplace (State or Foreign intry)
	pu >		Usual Residence of Dece 10a. State 10b.			10- (V4. T							
	sho	5		County			City, Town or							10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the N	Director	Maryland 10e. Street and Number	Mont	gomery	7	Silver	Spring 10f. Zip Code				40. 000	(1111 + 0	
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	death	Funeral	11. Marital Status	Jou. For			U.S. 13	. Was Decedent of H	lispanic Ori	igin? (Sp	ecify Yes or No-		4. Race - Amer	ican Indian.
9	after or Ite	교	1 Never Married 2	2☐ Married	1 A Yes	orces? 6/	1941 to				Rićan, etc.)		Black, White	, etc.
03	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diest Evantiner must be notified at	d by	3 ☑ Widowed 4 □ [Divorced	If Yes, G Year or I	Dates: 2/	1946	1 ☐ Yes 2 🖾 No	Specify:				Specify: Whi	te
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Maryland	o d is a	To Be	Alden Elon	Tmus	Sr.						M. Kli		,	
ary	2 should and Men Is marke sumatic	-	19a. Informant's Name/F				19b. Ma	ling Address (Street					Town, State, Zi	p Code)
	A		Benjamin A.	Imus /	Son		6232	Martin Ro	oad, (Colum	nbia. Ma	rvla	nd 2104	4
Baltimore,	ss 1 and 2 of Health litem 27		20a. Method of Dispositio		D	20b.		oosition (Name of ematory or other place			Date		ation - City or T	
Ĕ	mit. Pages 1 partment of H portant: If ite y injury or ott		1 ⊠ Burial 2 □ Cre 14 □ Donation 5 □ 0			Jiale		ans Cemete		01/28	3/2005	Che1	tnham,	Maryland
alt	permit. DepartmImportal		21. Signature of Funeral	Service Lieen	S00	1		22. Name and Addre	ss of Facilit	y HIN	NES-RINA	LDI	FUNERAL	HOME, INC.
	90 F 2 9		Nonany	A. Ve	« cen	he							r Sprin	g, MD 20904
			23a. Part1. Enter the dis shock, or heart failu	ease, or comp re. List only	olications that one cause on	caused the dea each line.	ath. Do not e	nter the mode of dyin	ng, such as	cardiac	or respiratory arr	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)		Due to	(or as a cons	uence of):	1 0	101	05 A	010			
		-	Sequentially list condition if any, leading to immedia cause. Enter Underlying	is,	b. 100 t	(or as a conse	Parence of):	-5 11	121		110	>		
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Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	- 1	c. Due to	(as conse	quence of):	- 1 -	0	-				
8760,	cate be executed physician and s the burial-transit	cal			0.)	40	60	6 4401	\$5	100	COLLEN	MA	+	
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit					[4	, , ,							
Вох	eath certific attending p i for use as f	an/N	IF FEMALE: 23b. Was decedent pregi	Idill		itcome of pregi		□Ectopic pregnancy	,			23	3d. Date of deliv	
	ne dea the at hed fo	Physician/Med	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	isr	4□Preg 9□Unkr	nant at time of	death 5	Other (specify)					Month	Day Year
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Vital		o Be	examiner?	-	Hospital: 1 N	Inpatient 2[TER/Outpatic	ent 3 DOA Oth			(Check anly on ne 5 ☐ Reside		(C)	
ot	ding Phys h. After this funeral di	-	27. Manner of Death		28a. Date	of Injury	28b. Time		y at		28d. Describe ho			y)
0	Attanding Frdeath. actor: After	atio	1 Matural 5 ☐ 2 ☐ Accident	Pending investigation	(MOI	nth, Day Year)	Injury		k? Yes 2.⊟1	No				
Division	er de racto by th	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	288. Placi	e of Injury - At I	nome, farm, s	treet, factory, office		1	28f. Location (SI City or Town		Number or Run	al Route Number,
۵	ital o	Cer		/						4				
	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	(Check only 2 N	Certifying Phy ledicel Exem	iner: On the b	asis of examin	owledge, dea	th occurred at the tim	ne, date an	d place, a	and due to the ca	ause(s) a	nd manner as s	tated.
	thin 2 the the mplet	Med	one) 29b. Signature and title of		and mar	iner stated.	0.4	29c. License						
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			30. Name and address of	MED	Completed oau	A MIN A	13° 17°	D. 33	21-	10	LISO	17	0,70	7(1)
	Sta	te	31. Date filed (Month, Day		32	egistrar's Sign	aturo	partie		<i>> \</i>	rr+1	1 1 (V. 20	0-
	Registr	ar	JAN	19 20	105	dus.	12 19							

	1 - For State Registrar	State of Maryla		artment of Heartificate of De			ene 1. 2005	03159
Physiciar /Medica		, Last)				2. Date of Death Month	Day Year	- 7 U M
Examinel Funeral Director	4a. Facility Name (If not institution 12409 Publ 5. Social Security Number 220 70 5255	give street and number)	s. last birthday) 75 Yrs.		Spund f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of De	
IZ15-UU36 within 72 hours after death with the Maryland sne near "neturel", or Items 23a or 28a4 show a Mudical Examinat must be notified at manieted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Mon 10e. Street and Number	Egomeny S.	Eity, Town or Lo	Sprin 101. Zip Code 200	4		g. Citizen of What C	A.
Z I Z I 3-UU30 Id within 72 hours after death w glene. er then "neturet; or items 23a if a Mudical Examiner must it Committed by Funeral I	3 □ Widowed 4 □ Divorced	If Yes, Give' Year or Dates:	16a. Deceo	lent's Usual Occupatio	Specify:	16	14. Race - Am Black, Wh Specify: A	sian
be filed that Hygis and other event, II	17. Father's Name (First, Middle,	College (1-4or 5+)	P.	op netter		(First, Middle, Ma	Prwaiden Sumame)	te
Dallimore, Marylation permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic even ones.	19a. Informant's me/Relationsi 20a. Method of Disposition 1	ng Daughter 2016. 3 □Removal from State No	Place of Dispo cemetery, cren	g Address (Street and sition (Name of natory or other place) Memory is Name and Address of	Number or Rura	I Route Number, of Live Sul ate 20	ver Spr	Zip Code) Town, State M D Sew US
Prrysician /Medical Examiner	snock, or near railure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused the deapony one cause on each line. a	quence of):	2363 Kauy er the mode of dying, s	such as cardiac of	we Upp r respiratory arrest	ren Maul	Approximate Interval Between Onset and Death 3 Years
ificate be executed g physician and as the burial-transit		c. Due to (or as a consect Due to (or as a consect d.						
the death certility the attending y the attending (ched for use a wigician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	liv <i>e</i> ry Day Year
es the igne	Part II. Other significant condition	ns contributing to death but not res	sulting in the ur	derlying cause given in	n Part I.		/	o the cause of death?
The The page	25. Was case referred to medical			26	S Place of Doub	24a. Was an autopsy performed 1 Yes 2 (Check only one)	prior to death?	utopsy findings available completion of cause of
_ % .º ie O	1 ☐ Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA Other: 28c. Injury at Work? M 1 Yes	4 Nursing Hom 2 2 No	ne 5 ⊠ Residenc 8d. Describe how		
To the Hospitel or Attending Philipping 24 hours after death. To the Funerel Director: After the completely filled in by the funeral Medical Certification:		building, etc. (Special building) building building, etc. (Special building) building buil	owledge, death	occurred at the time	date and place, a	City or Town, S	State)	estated
To the within To the comple	29b. Signature and title of certifier	2 who completed cause of death (Iter	m 23a) (Type. I	29c. License nu D 4.5	mber 5880		Date signed (Mont 2005 2077 4	h, Day, Year)
State Registrar	Len Hwang 31. Date filed (Month, Day, Year)	1221 Mercant 32. Registrar's Sign	ile L	ane, I	aigo,	MI) 2	20774	

			For State Registrar		State o	of Mary		epartmer Certifica			and Me	_	giene	005	031	60
			1. Decedent's Name (First, Mide	de, Last)							2	. Date of De	ath		3. Time of	Death
	Physici		Hollice	Lvnr	nette		Johnso	nn.				Month Januar	Day		13:06	М
	/Medic Examin		4a. Facility Name (If not instituti				OOMINDO		Town, o	r Location o		Januar		County of Deat)
	LAGITIII	C.	Prince George'	s Cor	nmunit	v Hosi	nital	Ch	ever	1 37			D	rince G	002001	
	Funeral		5. Social Security Number	6. Sex	MIGHT		yrs. last birth	day) If Unde	r 1 Year	If Under		. Date of Birt	th	9. Birt	hplace (State o	
н	Director		579-74-1585	1 🗆	M 2∭∏F	52	Y	rs. Months	Days	Hours	Min.	(Month, Da		Co	hingtor	_
	ъ		Usual Residence of Decedent									- L	, 1/	Je I Was	mingeon	سالا وا
	nylan how		10a. State 10b. Count	у		100	. City, Town	or Location							10d. Inside Ci	
	a Ma	ioi I	Maryland Prin	ce Ge	orge'	s	Capito	1 Heig	nts						1 XYes	2 □ No
	or 28	Director	10e. Street and Number						o Code				10g. Citi	zen of What Co	ountry?	
	15 wi		1008 Elderber	ry Pl	Lace				20743	3			Uni	ted Sta	tes	
	ems ems	Funeral	11. Marital Status	12	2. Was Dec Armed F	edent Ever	in U.S.	13. Was Dece If Yes, spe	dent of H	lispanic Ori	gin? (Speci	fy Yes or No		14. Race - Ame Black, White	ncan Indian,	
9	or Its		1 ☐ Never Married 2 ☐XMa	rried		2 X No		1 ☐ Yes		Specify:	.,	,,		0		
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deat Exactinating the notified at	d by	3 Widowed 4 Divorce	d	Year or [Dates:			-A					Specify. B	lack	
5-(n 72 ho "natur	Completed	15. Decede (Specify only high)	(Decedent's Usu Give kind of w	ork done	during mos	t of working		16b. Ki	nd of Business/	Industry	
21	d within giene. r than "	Idr	Elementary/Secondary (0-12)		•	1-4or 5+)		life. DO NOT i	ise retired	d)						
2	77				year	S	_	Spec	ial (Clerk		=		Private	(Veriz	on)
pu	d tal	Be	17. Father's Name (First, Middle	, Last)						18. Mothe	ers Name (i	First, Middle,	Maiden	Sumame)		
yla	should be ind Mental s markad o umatic eve	2	Miles C. Otey									. Coml				
Maryland	0 8 8		19a. Informant's Name/Relation											r Town, State, Z		
	1 and 2 Health Ism 27		Cheree Johnso	n – D	augnt									hts, MD		
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	1 3 □Re	moval from	State	cemetery	Disposition (Na r, crematory or	me or other plac	ce)	Dat		20c. Lo	cation - City or	Town, State	
Ē	permit. Page Department of Important: If any injury or once.		`4 ☐Donation 5 ☐ Other	(Specify)			t. Lin	coln Co	emete	ery J	Jan. 2	4, 200	05 1	Brentwo	od, MD	
alt	permit. Depart Import any inj		21. Signature of Funeral Service	e Libenshe	0	-1/2	The	22. Name a	nd Addre	ss of Facilit	y Stew	art Fu	inera	al Home	, Inc.	
<u> </u>	20 E # 9		JOING!	· M	Mes	120	HAL	4001	Benni	ing Ro	oad, N	IE Wash	ning	ton, DC	20019	
			23a. Part 1. Enter the disease, shock, of heart failure. Li	or complic st only one	ations that e cause on	caused the each line.	death. Do no	ot enter the mo	de of dyin	ng, such as	cardiac or r	espiratory ar	rrest,		Approximat Interval Bet	ween
	Pnysician :	d n	Immediate Cause (Final disease or condition		me	tax	tation	Can	I'N	UNICA	Ane	0151	-		Onset and I	
	/Medical		resulting in death)	(a.			nsequence of								1 000	-
	Examiner		Sequentially list conditions	b.												
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	"		(or as a con	nsequence of	f):								
	cute	Examine	Cause (Disease or injury that initiated events	С.												
0	be executed sician and burial-transit	E	resulting in death) Last		Due to	(or as a co	nsequence of	f):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		d.										-		
9	ntifica ng ph as th	Ned	IC CENALE.	12:						-			-			
Вох	eath certific attending p for use as 1	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23		itcome of pr		3 ⊟Ectopic p	regnancy	v			1 4	23d. Date of del	-	Y
	dea ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time		5 Other (s		,				Month	Day ^	Year
P.0	at the de by the a	h	9 Unknown										1			
	es that igned b	by F	Part II. Other significant condi	tions cont	tributing to	death but no	t resulting in	the underlying	cause giv	en in Part I.	•			se contribute to		
Records,	w require been si should I					<u> </u>						101	res 2€	No 3∏Pr	obabiy 4 □l	Jnknown
SCO	awre is be 2 sho	plet										24a. Was		24b. Were au	topsy findings	available
	The lavate has page 2	Completed										perfo	rmed?	death?	2□ No	8036 01
Vital		a	25. Was case referred to medic	cal						26. Place	of Death (Check only o				
<u>></u>	N S	To B	examiner? 1 ☐ Yes 2 ☐ No	Н	ospital:	Inpatient	2 ER/Out	patient 3 D	OA Oth	ner: 4 □ Nu	ırsing Home	5 Resid	dence 6	3 ☐Other (Spec	cify)	
of			27. Manner of Death		28a. Date	of Injury oth, Day Yea	28b. Ti	me of jury	28c. Injur Wor	y at	28	d. Describe h	now injur	y occurred		
ioi	Attanding F r death. actor: After by the funera	atio	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ding stigation	(1070)	nin, bay ro		M		Yes 2	No					
Division	f or Attand after death Diractor: ,	ific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined	28e. Plac	e of Injury -	At home, fari	m, street, facto	y, office		28	f. Location (5 City or Tox		d Number or Ru	ıral Route Num	ber,
ā	al or A s after Il Dira	Certification;	4 Difficial		Dalic	arig, etc. (5)	oochy)					Oily or Tor	vii, State,	/		
	a Hospital or 24 hours afte 5 Funaral Dira etely filled in b		29a. Certifier 1 Certify	ing Physi	ician: To th	e best of my	knowledge,	death occurred	at the tir	me, date an	d place, an	d due to the	cause(s)	and manner as	stated.	
		edical	(Check only 2 Medica one)	ıı Examını	er: On the land mai	nasis of exa	mination and	vor investigatio	n, in my o	pinion, dea	ın occurred	at the time,	date and	place, and due	to the cause(s	-)
	Totha within 2	ž	29b. Signature and title of certif	· ·	2			1		e number			29d. Dat	e signed (Monti	h, Day, Year)	
) ((5)		Amola	na	un	rel	w	4	00	182	2_	-	JAN	UANY Z	0 200	5-
(1610		30 Name and address of person	n who cor	npleted cau	ise of death	(Item 23a) (1	Type, Print)								
	0		Paul A. D	EV	one	MD4	2036)veen	560	my Re	HE	gatt	Suil	le Mb	207	احق
	Sta	ite	31. Date filed (Month, Day, Yea	ir)	32.	Registrar's S	Signature									
	Regist	rar	JAN 2 1 2005	Ma	Eur.	NY A	book									

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of Health and rtificate of Death		ene 2005	03161
	Physici /Media	cal	L10	ANN	JACKS		2. Date of Death Month	Day Year 2005	3. Time of Death
	Examir Funeral	ier	4a. Facility Name (If not institution, give COLLEGE VIE 5. Social Security Number 6. Security Number	W CEN	(In yrs. last birthday)	4b. City, Town, or Location of De FREDERICA If Under 1 Year If Under 24 F Months Days Hours M	rs. 8. Date of Birth	4c. County of Death FIZEDE 7	place (State or Foreign
N.	Director wow	J.	Usual Residence of Decedent 10a. State 10b. County Md. FREDERIC	1M 200F	30 Yrs. 10c. City, Town or Li FREDERI	ocation	April 15	7974	10d. Inside City Limits
	hours after death with the Maryland tural; or Itema 23a or 28a-f ehow al Exercit Mrman be rediffed at	erai Director	10e. Street and Number	Court		10f. Zip Code 21702		g. Citizen of What Cou	intry?
9003	72 hours after de natural', or Item	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - Ameri Black, White Specify: BL	ACK
121215-0036	within 72 jiene. r than nai	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 771 17. Father's Name (First, Middle, Last)		(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) MESTIC	vorking	6b. Kind of Business/le	
Maryland	should be filed of Mental Hygumarked othe Imarked othe Imatic event,	To Be	TOSEPI+ LEE 19a. Informant's Name/Relationship (Ty					1 KORRE	
ā,	Pages 1 and 2 should nent of Health and Mer ent: If Item 27 Is marke ury or other traumatic		PATRICIA KORRI 20a. Method of Disposition 1 Burial 2 Cremation 3 GR 4 Donation 5 Other (Specify)	the (moi	20b. Place of Dispo cemetery, cre	VIENNA COUR	RT FREDE		21702
Baltir	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service License Muy A. Fol		.1.	2. Name and Address of Facility ARY C. ROWN AWEST SOUTH			
8760,	Physician /Medical Examiner the private and the private	ai Examiner	23a. Part1. Enter the disease, or complishock, or beart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a		Ier the mode of dying, such as card	\ \		Approximate Interval Between Onset and Death 3 4 £ AR S
.O. Box 687	eath certificate attencing physical for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{EVNO} \) 9 \(\text{Unknown} \) Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
۵.	es that gned b	by	Part II. Other significant conditions cor	tributing to death bu	t not resulting in the u	nderlying cause given in Part I.		cco use contribute lo t	
al Reco	The law ate has b page 2 sl	Completed					24a. Was an autopsy perform	ed? prior to co	opsy findings available impletion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1	28b. Time o	nt 3 DOA Cther: 4 Nursing	Home 5 Resident Resid	ice 6 □Other (Speci	(y)
Divisi	irec irec irec	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, sti (Specify)		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of On the basis of and manner stat	examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death oc	ice, and due to the cau courred at the time, dat	use(s) and manner as s e and place, and due t	stated. o the cause(s)
}	To To T	Σ	29b. Signature and title/of certifier	J cas		29c. License number D - 31913	2	d. Date signed (Month,	05
	3		04 0-1-61-4 04-41 0 14 1	17, 1554	ath (Item 23a) (Type,	Print)	FAZDE RI	ich mD	21702
A	Sta Registr		JAN 2 0 2	005 32. Hagi-trai	's Signature	3000			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wootnie Carr Jackson January 07, 2005 5**:**11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 3805 Quincy Street Hyattsville Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 21,1984 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 216-21-0608 Months 10XM 2□ F 20 Director Washington DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 7 is markad other than "natural", or Items 23a or 28a-f show traumatic avant, the Medical Examinar must be notified at 1√ Yes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Raleigh Street SE 20032 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNO Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 is markad othar th Unemployed Twe1th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Forrest Carr Miller Jr Irene Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or othar traun 331 Raleigh St SE, Washington DC 20032 Forrest Miller/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2005 Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Cemetery January 15 Landover Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens, 22. Name and Address of FacilityRobert G. Mason Funeral Home Me//// 1661 Cood Hope Rd SE, Washington DC 20020 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple bunshot /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): the attending physician Box 68760 certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an Was all autopsy performed?
Yes 2 No 1X Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funaral Diractor: After 5 Pending 1 Natural 1 ☐ Yes 2 🗹 No investigation 4:58 A M Subject was shot 7/05 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 32.05 Quinty STIECT 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street Hyattsville, mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 07, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 JAN 1 9 2005 State

Registrar

			1 - For Amend Item 19	State of M Pa per fh	laryland / De G840 2-1	partmen 2-05 ta ertificati	t of He	ealth an <i>eath</i>	d Mental Hy	/giene	7.5	00160
	Physic	ian	1. Decedent's Name (First, Middle, Las						2. Date of D Month		10	3. Time of Death
	Physic /Medi		Blanche A						Jan.		Year 0 0 5	3:30 A M
	Exami	ner	4a. Facility Name (If not institution, give)			ocation of D	eath	4c. County		
	Funanal	-	4034 Old You 5. Social Security Number 6. S		ge (In yrs. last birtho		nkto	n If Under 24 i	drs. 9 Data of Bi	Hari		10.
	Funeral Director			□M 2只F	89 Yrs	Months	Days		1 1 2 / 2	9/1916	P. Birthpi Coun: Ma	ace (State or Foreign try) ryland
	yland		10a. State 10b. County		10c. City, Town o	r Location					10	Od. Inside City Limits
	the Maryland r 28a-f show	ctor	Md. Har:	ford	Mo	nkton	l					1 ☐ Yes 2 ☐ No
	death with the Maryland me 23e or 28a-f show	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of W	hat Count	try?
	e 23e		4034 Old					111			S.A	•
36	after or Ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	? [No	3. Was Deced If Yes, spec		panic Origin? Mexican, Pi Specify:	(Specify Yes or Ni lerto Rican, etc.)		· America k, White, e Bla	etc.
5-0036	72 hours neturel',		15. Decedent's Ed	ucation	16a, De	cedent's Usua	I Occupati	on		16b. Kind of Bu		
215	C	Completed	(Specify only highest gra	de completed) College (1-4or	5+) (G	ive kind of wor e. DO NOT us	rk done dui se retired)	ring most of	working	TOD. TRITTO OF BE	3111033V111U	Dolly
2121	be filed withle tral Hygiene. od other than event, the M	Con	8			Housew	ife			Н	ome	
and	a a a	Be	17. Father's Name (First, Middle, Last)	a			1		Name (First, Middle		,	
100	2 should be and Mental le marked or aumatic ev	Lo	Charles Edward						tie Atta			
Maryland			19a. Informant's Name/Relationship (7	- 1 a	4				Rural Route Numb			Code) 1111
	is 1 and of Health item 27 other tr		Mae Sterrett/d. 20a. Method of Disposition	augncer-	20b. Place of Di	sposition (Nam	ne of) I I I I I	Date	20c. Location - (
e E	Pages nent of I int: If it		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		cemetery, o	rematory or ot	ther place)		/21 /05		•	
Baltimore,	- E 2 5		21. Signature of Funeral Service Licen:		Union				rrettsv			Maryland 21084
Ö	permi Depa Impo any ir once		1 Bondamin 1	1. Knit	5				Son Fune			P. A.
			23a. Part1. Enter the disease, or composhock, or heart allure. List only	lications that pauce	the death. Do not ine.							Approximate Interval Between
	Pnysician	į. 19	Immediate Cause (Final disease or condition	. JH	YPERTE		1.0					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):			. 15	Yes.			
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	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	- Due to (or as	T P. 1							
~	execun n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	-					_	•
68760,	icate be executed physician and s the burial-transit	edicail		d.								
Вох	leath certific attending pi	Physician/M	200. Tras decedent program	23c. If yes, outcome 1□Live birth		3 □Ectopic pre	agnancy			23d. Date		/
.O.	ne des the at hed fo	/sici	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown		5 ☐ Other (spe				Mont	h [ay Year
0	that the de ed by the detached	Phy	Part II. Other significant conditions co	ntributing to death h	aut not reculting in the	. undorbina en		in Donal	as Did			(1)
Vital Records,	The law requires that the death certif tte has been signed by the attending tage 2 should be detached for use a	D		This disting to death b		underlying ca	iuse given	in Part I.	239. Did (obacco use contrib		cause of death?
lec	e law has b je 2 st	Completed							24a. Was	an 24b. W	ere autops	y findings available pletion of cause of
al F									perfo	rmęd? de	ath?	No
V.	Phyeician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			044		eath (Check only o			
of	Phys r this ral di	. To	1 ☐ Yes 2 € No 27. Manner of Death	1 🔲 Inpatie			lc. Injury at		Home 5 Resid	dence 6 Other		
OU	ding Ith.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) Injur	, M	Work?	s 2 🗆 No	200. Describe i	low injury occurred	1	
Division	r Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, c. (Specify)				28f. Location (S	Street and Number	or Rural F	Route Number.
Ö	s afte	Cert	4 Horridge	building, et	c. (Specify)				City or Tow	vn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying Phy	sician: To the best ner: On the basis of and manner sta	of my knowledge, de f examination and/or ated.	ath occurred a investigation, i	t the time, in my opini	date and pla on, death oc	ce, and due to the curred at the time,	cause(s) and manr date and place, an	er as stat d due to th	ed. ne cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier			29c.	License no	umber		29d. Date signed (Month, Da	ay, Year)
•	Ţ		MY W.K.	5 MD)	D	368	46		JANUANY	27	2005
	H		30. Name and address of person who co	moleted cause of d	eath (Item 23a) (Typ	e, Print)	1		\		- 4	
			SERWAND H-RAU	It mes.	3601 Loc	H Ryvi	TU BI	VD Su	TE 208-A	BATTISHUI	Em	021239
	Sta Registr		FEB 0 2 200	32 negistr	ar's Signature	reste						

			State of Maryland / De	partment of Health and Mertificate of Death	•	ene 2005	03164
н	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Lorene Virginia Keener			21 2005	07:30M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0	4c. County of Dea	th
	Francis		Washuington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washingt	
	Funeral Director		213-42-1750 1 M 2XF 84 Yrs	Months Days Hours Min.	Month, Day, Ye April 12	9. Bir Co	thplace (State or Foreign puntry)
	2		Usual Residence of Decedent		Whill IS	1920 Mar	yland
	anytar show	-	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	he M	ecto	Maryland Washington MAUGANS				1 □Yes 2 No
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dical Exaculture ust be notified at	Funeral Director	1/100 are	10f. Zip Code		Citizen of What Co	ountry?
	Jeath	era	14129 Maugansville Road 11. Marital Status 12. Was Decedent Ever in U.S. 1	21767 3 Was Decedent of Hispanic Origin? (Spe		S.A.	ocan Indian
(0	r lter	표	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
g	ours a	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ሺ No Specify:		Specify: Whi	t e
5-0	72 hours "naturel", dical Ex.	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	16t	. Kind of Business	
21	d within giene. r than "	ld u	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of worki DO NOT use retired)	ing		
22			12 Ho	nemaker		Domestic	
Maryland 21215-0036	d tal	o Be	Vernon Eckard		(First, Middle, Maid	den Sumame)	
<u> </u>	and Meni and Meni Is marke	ř		Virgie iling Address (Street and Number or Rura	Shenk Shenk	tu or Tour State	Z'- Codel
	s 1 and 2 should t Health and Mer ttem 27 is marks other traumatic		M	25 Maugansville Roa			
Baltimore,	s 1 a if Hea item othe		20a. Method of Disposition 20b. Place of Dis			Location - City or	
E	Pages nent of int: If it		Modular 5 Determation 3 Determoval from State	en Cemetery 1/25/	/05 Ha		M 1
alti	permit. Pag Department Important: I any injury o		21. Sign Jura 1 Funeral Servic y censee		st Haven	gerstown Funeral C	
<u> </u>	89 E 8 8		70 /5	601 Pennsylvania Av			
В			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition and condition	SART FAILURE			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	77.1.0			~ J WEEKI
	Examine:	ايا	Sequentially list conditions b. ALUTE MYOCAN	DIAL INFARCTIO	N		2-3 WEEKS
	sit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A att wa			
	al-tra	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):	NA 110 D-115			YEARS
8760,	rate be executed hysicien and the burial-transit	calE					
68	.º L.		0.				
Вох	that the death certif ed by the attending detached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	C		23d. Date of deli	verv
	deat	Sicia	1 Yes 2 No 4 Pregnant at time of death	□Ectopic pregnancy □ Other (specify)		Month	Day Year
о. О.	at the I by the stach	hy	9 Unknown 9 Unknown				
	ires tha signed d be det	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc		the cause of death?
orc	w requir been si should	sted	TYPE I DIABETES MELLITUS	HAPERTENTION	1 Tes	2,⊠No 3□Pro	obably 4 Dunknown
Division of Vital Records,	e law has b	Completed	RENAL INSUFFICIENCY PHEUR	IONIA	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
a					performed		2 No
Ξ	or Attending Physicien: ther death. Director: After this certifics in by the funeral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
of	Phys rr this sral di	. To	1 Yes 2 No Tospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending	4 Nursing Horn	ne 5 Residence 8d. Describe how in		ify)
ion	nding ith. :: Afte e fune	it or	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	54. D056/156 1164 11	july occurred	
Vis	Attend or death. ector: A by the fi	120	3 Suicide 6 Could not be	treet, factory, office	8f. Location (Street	and Number or Rui	ral Route Number,
	tal or A	Certification;	4 Homicide Softmines building, etc. (Specify)		City or Town, Sta	ate)	
	Hospital or Attending I 4 hours after death. Funerel Director: After tely filled in by the funer	edical	29a. Certifier (Check only (C	th occurred at the time, date and place, ar	nd due to the cause	(s) and manner as	stated.
	To the Hospital or within 24 hours afte To the Funerel Discompletely filled in	Medi	one) and manner stated.		u at the time, date a	ind place, and due	to the cause(s)
	o T with	4	29b. Signalure and title of certifier	29c. License number	29d. [Date signed (Month	. Day, Year)
		-	tand tot sooph	D38892	1	124105	
À.	4 .1		30. Name and address of person who completed cause of death (Item 23a) (Typ.	Print) SUITE 130	a) H	4 GERSTON	IN.
1	4-/ Sta	te	31. Date filed (Month, Deux Year) 32. Registrar's Signature	OITOICAL CATIFUS	NO 1	10 217	4.2
	Registra	_		nede			

			1 - For State Registrar	State o	f Maryland / [rtment of He tificate of D		d Mental I	Hygien	$Z \cup U$	5	03165
	r		Decedent's Name (First, Middle, La	st)					2. Date o	f Death	_		3. Time of Death
	Physici		Marca Elizabeth	Vorr					Janua	_	ay 3, 200	Year NE	11:00 p.m.
	/Medio Examir		4a. Facility Name (If not institution, giv		mber)		4b. City, Town, or	Location of De			c. County o		11:00 p.m.
1	Examili	ei	St. Mary's Nursi				Leonard				St. N	lars,	1 .
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 24 I	Irs. 8. Date o	f Birth , Day, Yea			lace (State or Foreign try)
	Funeral Director			□M 2 X F	86	Yrs.	Months Days	Hours N	Iin. (Month	18 Yea	ที่ 1918 โ	Coun Jash	ington, D.C
			Usual Residence of Decedent						July	10,		Tabii.	ingcon, b.o
	yland		10a. State 10b. County		10c. City, Tow	n or Loc	cation					1	0d. Inside City Limits
	Mar Han	ģ	Maryland St. Ma	rv's	Leona	ardt	own						1 ☐ Yes 2 X No
	288 n	rec	10e. Street and Number				10f. Zip Code			10g. C	itizen of W	hat Cour	try?
	3a o	0	22680 Cedar Lane	Court #	3206		20650			1	J.S.A.		
	ms 2	era	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	panic Origin?	(Specify Yes o		14. Race	- Americ	
(0	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show its Medical Examirer must be nutitled at	Funeral Director	1 Never Married XX Married	Armed Fo 1 ☐ Yes If Yes, Gi					ieπo Hican, etc.)		, White,	etc.
8	urs a	by	3 Widowed 4 Divorced	If Yes, Gr Year or D	ve lates:	1	Yes XXNo	Specify:			Specify:	Whit	:e
215-0036	2 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a.	Deced	ent's Usual Occupa kind of work done di	tion	working	16b.	Kind of Bus	iness/Ind	lustry
215	hin 7	pld	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	oring most or	Working				
21	d wit	Ö	12			Home	Maker)wn Ho	me	
	othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mic	ddle, Maide	n Sumame)	
<u>a</u>	Alenta Alenta rked tlc e	To	Luther Greaver					Ida E.	Sirles	3			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be nutified at once.		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailin	g Address (Street ar	nd Number o	Rural Route No	ımber, City	or Town, S	tate, Zip	Code)
Σ	alth a		Emory Russell Ke	rr / Hus	sband 22	2680	Cedar La	ne CT.	, #3206	Leon	nardto	wn,	MD 20650
re,	s 1 a othe		20a. Method of Disposition	3-	20b. Place of	f Dispos	sition (Name of natory or other place)	Date		Location - C		
Ë	Page ent c nt: If		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		State	-	el's Cem.	1	1. 28 'C) 5 F	Ridge.	Мат	yland
Baltimore	orte		21. Signature of Funeral Service Life		7		Name and Address						
B	permit Deper fmpoi eny ir		Edward N. Brinsfi	eld. Jr	м00052								land 20650
	-		23a. Part1. Enter the disease, or com	plications that	aused the death. Do i	$\overline{}$,		Approximate
8.	II		shock, or heart failure. List only Immediate Cause (Final	one cause on e	each line.	0	heard	-	relien	-			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a consequence	-6\:	We ou or	, 1	Ciri Co				
	Examiner			Due to	Pneum	,	419						
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consequence		,						
	ted nslt	Examiner	cause. Enter Underlying Cause (Disease or injury										
	xecu and al-tra	xai	that initiated events resulting in death) Last	c	(or as a consequence	of):							
8760,	cate be executed physician and s the burial-transit	a E	l l										
387	phys the	dlcal		d									
×	death certific e attending p id for use as f		IF FEMALE:	23c. If ves. ou	tcome of pregnancy						23d. Date	of delive	ny.
Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live b	pirth 2 Fetal death		Ectopic pregnancy Other (specify)				Mont		Day Year
o.	0 0 0	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkn		0	Outon (3000117)						
P.0	requires thet the death cer neen signed by the attendir hould be detached for use	F.	Part II. Other significant conditions	contributing to d	eath but not resulting in	n the un	derlying cause give	n in Part I.	23e. [Did tobacco	use contrib	oute to th	e cause of death?
Records,	signe signe	by					, ,			Yes	2 □ No 3	B ☐ Prob	ably 4 DUnknown
9	w require been si should I	Completed									1		,
ec	~ D (A	J de							_ a	Vas an lutopsy	pr	or to cor	osy findings available npletion of cause of
	The law cate has page 2	Ö							1 🗆 Y	erformed? es 200 N		ath? Yes	2 No
ita	ılclən: Th certificate rector, paç	Be (25. Was case referred to medical examiner?						Death (Check o	nly one)			7
of Vital	Physicien: r this certifica ral director, p	2	1 ☐ Yes 2 No	Hospital: 1 🗆	Inpatient 2 ER/Ou	tpatient		4 IAI Nursin	g Home 5□F)
	ding Pi h. After th funera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon		Time of njury	28c. Injury Work	at ?	28d. Descr	ibe how inj	ury occurre	d	
Division	Attending r death. ector: After by the fune	atle	2 Accident investigation				M 1 □ Y	es 2 No					
<u>Vis</u>	Atte	tiflo	3 Suicide 6 Could not be determined	280. Place	of Injury - At home, faing, etc. (Specify)	ırm, stre	est, factory, office		28f. Location City or	on (Street a	and Number te)	or Rura	Route Number,
	s effe s effe el Dir	Certification:			J. 1, 7,		_						
	Hospitel 4 hours e Funerel tely filled				a best of my knowledge asis of examination an								
	He He	Medical	one)	and man	ner stated.	ovor inv	estigation, in my opi	inion, death o	ccurred at the ti	me, date al	nu piace, ar	id due to	the cause(s)
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1			29c. License		^		ate signed		
	SAE		1	uall			D	1706	6).	25	.0	5
•	2		30. Name and address of person who	completed cau	se of death (Item 23a)	(Туре, Г	Print)						
)		Avani D. Shah, N		22650 Ceda			Leona	rdtown	Mary1	and 2	0650	
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signature	As	A						
	Regist		JAN 2	בטעט ל	francon o		Annal 1						

DHMH 17 Rev 1/2001

ended		Registrar # 19b pe 1. Decedent's Name (First, Middle, Last)	rfh,gc,1/2	20/050			- :	2. Date of Dea			3. Time of D	Death
Physic /Modi		EDNA MA	E KIRKLAND					Month January	Day 15.20	Year 005	4:55	\mathbf{P}^{M}
/Medi Exami		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location o				inty of Death	-	
		MANOR CARE NURSING			LARGO	ar lifthadas	0.4 Hen	0.0 (.0)		CE GEOI		
Funeral		5. Social Security Number 6. Sex	M 2 √2√ F	rs. last birthday Yrs.	Months Day		Min.	8. Date of Birth (Month, Da)	y, Year)		lace (State or	
Director	4	578-74-1503 Usuel Residence of Decedent	50					Oct. 1,	1954	BLOO	klyn,N.	Y
rylanc how		10a. State 10b. County	10c.	City, Town or L	ocation					1	0d. Inside City	
Ba-f s	Director	Maryland Prince Geo	orge's Te	mple Hi					10 00	-4330 - 4 0		2 140
n 72 hours after death with the Maryland "naturat, or items 23e or 28e-f show edical Examinar rust be mailthed at		10e. Street and Number			10f. Zip Code				-	of What Cour	itry?	
eath	Funeral	5947 Fisher Road A	Apt. 102 12. Was Decedent Ever in	U.S. 13.	. Was Decedent of If Yes, specify C	748 of Hispanic Ori	gin? (Spec	cify Yes or No-		.S.A. Race - Americ		
or iten		1 Never Married 2 Married	Amed Forces? 1 Yes 27 No If Yes, Give				n, Puerto R	Rican, etc.)		Black, White,	etc.	
hours after tural', or ite al Examinu	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1□ Yes XX						lack	
n 72 h "natu	Completed	15. Decedent's Edui (Specify only highest grade		16a. Deci (Giv	edent's Usual Oci e kind of work doi DO NOT use ret	cupation ne during mos pired)	t of workin	g	16b. Kind of	f Business/Inc	dustry	
within 72 ene. than "na he Medic	l m	Elementary/Secondary (0-12)	College (1-4or 5+)		ronmenta				Priva	te Ind	netrv	
filed Hygi other	0	12th 17. Father's Name (First, Middle, Last)		PHAT	COMMENTA			(First, Middle,			usery	
Aental Aental rked	0	Charlie Kirkland					Mary	Johnso	on			
d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (Ty		. 4	ling Address (Stre							-
1 and 3 Health em 27		Juanita Kirkland-J		- Arrestant	l Spring			Oxon H:		ary Lan on - City or To		<u> </u>
Ses If it of or o		20a. Method of Disposition 1 ₩ Burial 2 □ Cremation 3 □ R	emoval from State		oosition (Name of ematory or other p	1				·		
E 40 -3		' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cemeter 22. Name and Ad	-	1/21/	05 V	dashin	gton,	D.C.	_
permit. Departi Import any inj		Salar Cill		10.7			·/	-				
	•	I THOMAY, Up dan	1000 MA12'	7//	razier's						00001	
		23a. Part 1. Enter the disease, or compli	nam MO13'	7//						h.,DG	20001 Approximate Interval Betw	reen
Physician	ſ	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	eath. Do not e	89 Rhode nter the mode of o					h.,DC	20001 Approximate Interval Betw Onset and D	een
Physician /Medical		shock, or heart failure. List only or	MOM MO 13 decirations that caused the decause on each line. a. METASTATI Due to (or as a cons	eath. Do not el	89 Rhode nter the mode of o					h.,DC	Interval Betw	een
		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	me cause on each line. a. METASTATI Due to (or as a cons CANCER OF	eath. Do not elected. Do not elected. BRAIN sequence of): LUNG	89 Rhode nter the mode of o					h.,DC	Interval Betw	een
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Medical Examiner Size of the prical and prical-transit is purial-transit.	ical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. METASTATI Due to (or as a cons CANCER OF Due to (or as a cons	eath. Do not elected by the sequence of):	89 Rhode nter the mode of o					h.,DC	Interval Betw	een
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Bertha Kinard January 2005 1010 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) Ian. 31, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Hours Min 1□M 2√1F Yrs. 98 578-62-0936 1906 North Carolina Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Washington 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code ŏ #35 Hamilton St., N.W. 20011 United States or Items 23a Funeral 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: **Black** þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alonzo Newsome Gennie Best 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 le m any injury or other traum <u>once.</u> James Newsome - Nephew P.O. Box 962, Goldsboro, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Lincoln Memorial Cem. 1/15/2005 Suitland, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fufferal Service License Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysiçian Acute Myocardial Infarction /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of): Examine ician and burial-transit Hypertension Due to (or as a consequence of): attending physician for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown/ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Dale of Injury 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tle of certifier Jan. 12. 2005. s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre De mocray Blud, 320 32. Registrar's Signature State Registrar

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			Decedent's Name (Firs	t, Middle, La	st)						2. Date of De	ath		3. Time of Death
	Physicia /Medic		Madeline An	agnos	Kostop	ulos					Januar	Day y 12	Year 2005	10:01 P M
	Examin		4a. Facility Name (If not in	_					4b. City, Town, or	Location of Death	1		County of Deat	
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	filed within 72 hours eller death with the Maryland Hygiene. Hygiene then "natural", or Items 23a or 28e-f show ent. It e Madical Examiner must be notified at	Funeral Director	11. Marital Status	25 000	12. Was De	ecedent E Forces?	ver in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No)-	14. Race - Ame Black, While	
2	or Its	y Fu	1 Never Married 2			s 20 N	D		1 ☐ Yes 2 ☐ No	Specify:	5 7 115d 11, 515.7			nite
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N N	12 sh h and 7 Ism treum		19a. Informant's Name/R					19b. Mailir 4500	ng Address (Street Dexter S	and Number or Ru St. N.W.,	Washi Washi	er, City o ngto	n, D.C.	20007
ກ <u>ົ</u>	permit. Pages 1 and 2 should be filed within 72 hours etter death with the Marylan Department of Health and Mental Hygiene. Propertment of Health and Mental Hygiene. I have considered to the rithen "natural", or Itames 28 or 28e-1 show any Injury or-Other treumatic event. It a Medical Examinat must be notified at once.		20a. Method of Dispositio		, , ,		20b. P	lace of Dispo	sition (Name of		Date		ocation - City or	Town, Slate
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Vital	sician: The law s certificate has b lirector, page 2 si	o Be	25. Was case referred to examiner? 1 Yes 2	medical	Hospital:			ER/Outpatie	nt 3 DOA Oth	26. Place of Dea	th (Check only lome 5 ☐ Res		6 MOther (See	2.6.1
0	Phy ar this eral d	<u>}-</u>	27. Manner of Death		28a.	te of Injur	y	28b. Time o	f 28c. Injur	rv at	28d. Describe			sily)
<u>0</u>	nding ath. r: Afte e fun	atio	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation		fonth, Day	rear)	Injury	M 1	Yes 2 □No				
DIVISION	r Atte	Certification:	3 Suicide 6 [4 Homicide	Could not be determined	288. Pi	ace of Inju	ry - At h	ome, farm, st	reet, factory, office		28f. Location (City or To			ıral Route Number,
	oital o urs aft irei Di			6			, ,							
	Hosp 24 ho Fune stely f	Medical			miner: On the		examina		h occurred at the til vestigation, in my o					
	To the Hospital or Attending Physician: within 24 hours after death To the Funerel Director. After this certific completely filed in by the funeral director.	Mec	29b. Signature and title of	of certifier	11		1.5"		29c. Licens	se number		29d. Da	te signed (Monti	h. Day, Year)
			1 1	4 (59)	NIT				DC	41162	_	7	97400	132005
	>		30. Name and address o	f person who									1 h	2022
			31. Date filed (Month, Da	14MF	19	5 2	9	Dec	(cl)	17/1/6	66	was	1/com 1	ND 208-74
	Sta Registi		JAN		005 7	Tradistra	u s signa	K Ap	roles					
						-								

			State of Maryland / Department of Hea 1- State Registrar Certificate of Department	alth and M	lental Hyg	_	5 03169
	Physicia	an	1. Decedent's Name (First, Middle, Last) James Albert Ketner		2. Date of Dea Month	th Day Yee	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital Takoma		01	4c. County of De	eath
	Funeral Director		579-09-1448 08 M 2 F 89 Yrs. Months Days H	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2	Q B	irthplace (State or Foreign Country) Maryland
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	ath with the 23a or 28	ral Directo	10e. Street and Number 10f. Zip Code 10604 South Dunmoor Drive 20901			USA	
	be filed within 72 hours after death with the Maryland hat Hygiene. A thygiene ad other than "natural", or itams 23a or 28a-f show avant, the Madical Examinar must be nutilised at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WWII	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: W	
20-0-0	ithin 72 hou ne. nan "nature Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done durin, life. DO NOT use retired)	n ng most of worki	ing	16b. Kind of Busines	s/Industry
		a				Electric Maiden Surname)	Company
Wan y	permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked any injury or other traumatic av pnce.	To	James H. D. Ketner 19a. Informant's Name/Relationship (Type, Print) Abigail V. Ketner/ Wife 10604 South Dur	Number or Rura		r, City or Town, State	
ָרָ מ	Pages 1 ar		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery	! [oate ry 22	20c. Location - City of	or Town, State
Dall	permit. Departrr Importa any inju		21. Signature of Funeral Service Licensee Anne Marie Parker 500 University	ty Blvd	Funeral , W, Si	Home Inc lver Sprin	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	uch as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
Ļ	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
,00,	ate be executed nysician and he burial-transit	ical Exar	that initiated events c. Due to (or as a consequence of):				
O. BOX 00	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To tha Funata Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of c Month	delivery Day Year
L (cn)	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.			to the cause of death? Probably 4 Unknown
ושברסו	sician: The law rer certificate has bee irector, page 2 sho	completed	Premore Fisheletan		24a. Was a autops perform	sy prior to med? death	autopsy findings available o completion of cause of ? es 2 \(\) No
N VICAL	hysician: The I his certificate ha I director, page	To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		h <i>(Check only</i> or ome 5□ Resid	ne) ence 6 □Other (Sp	pecify)
	r Attending Ph er death. ractor: After th by the funeral	Certification:	2 Accident	s 2 □ No		ow injury occurred	Charl Court About
	To the Hospital or Attending Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral directors.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, of		City or Tow	n, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To tha Funaral Discompletely filled in	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated.	ion, death occurr	red at the time, d		ue to the cause(s)
/	<i>D</i>		Day May			1/18/05	4
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uhltherian Francis Reagan, M.D. 2100 Pennsylvania		NW, Wa	shington,	DC 20037
	Sta Registr		31. Date filed (Month, Day, Year) 33. Registrar's Signature				

DHMH 17 Rev 1/2001

				1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M	ental Hygie	2005 03170
		5 1	*	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
		Physic /Medi		Helen Jordan Kendall		Month January 23,	Day Year 1:40 P M
		Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death
				Harford Memorial Hospital	Havre de Grace If Under 1 Year If Under 24 Hrs.		Harford
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 94 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
				Usual Residence of Decedent		July 10, 19	10 New Jersey
		arylar show	_	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
		filed within 72 hours after death with the Maryland Hygiene ther then "naturel", or Items 23e or 28a-f show ont, the Medical Examiner must be motified at	Director	MD Harford Abo	ndeen		1 ¹ ⁄2 Yes 2 □ No
		with t	Dir		10f. Zip Code	10g.	Citizen of What Country?
deren.		ns 23	Funeral	446 Ruby Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.1	21001 Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	U.S.A. 14. Race - American Indian,
7	9	after o		1 Never Married 2 Married 1 TYes 2 No 1	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
2	215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗹 No Specify:		Specify: White
40	5-0	72 hours "naturel",	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of workir DO NOT use retired)	166	. Kind of Business/Industry
4.	121	within ene. then	mp	Conege (1-40134)			
-	d 21	be filed withir ital Hygiene. Id other then event, its M	e C	12 Sec 17. Father's Name (First, Middle, Last)	retarial 18. Mother's Name		secretary
	lan		To B	Walter Milton Jordan	Sara B		on Sumame)
	Maryland	d 2 should be filed th and Mental Hygis 7 Is marked other traumatic event, I	-		g Address (Street and Number or Rural		ty or Town, State, Zip Code)
05		- E N =			by Drive, Aberdeen, Ma		
	altimore,	T of S		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposemetery, crem	sition (Name of Datory or other place)	ate 20c	. Location - City or Town, State
3	Ë	Pages ment of I tent: If its		'4 □Donation 5 □Other (Specify) Fast View C	emetery 01/27/2	2005 Sa	lem, New Jersey
12	3ali	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	Name and Address of Facility Largo Funeral Ho		
		00 = 0 Q	1	your Carlotter 1 33	3 South Parke St., Abe	rdeen, Mary	land 21001
_		440		23a. Part1. Enter the disease, or comblications that caused the death. Do not entended shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of trying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
		Physician /Medical	i I	disease or condition resulting in death)	NON TO		
W		Examiner		Due to (or as a consequence of):			
•			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
		be executed ician and burial-transit	Examine	that initiated events			
	0,0	ate be executed hysician and the burial-transii	Ex	resulting in death) Last Due to (or as a consequence of):			
	8760,	ate hys	Physician/Medical	d			
	ox 6	ding p	/Мес	IF FEMALE:			
3	Bo	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	cian	If the past 12 months:	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
E	o.	that the di ed by the detached	ysk	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Ottler (specify)		
le	Д,	es that igned b be deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
1	rds	w requires been sign should be	ed b			1 🗆 Yes	2 No 3 Probably 4 Unknown
1	Vital Reco	e law requ has been je 2 shouk	Completed			24a. Was an	24b. Were autopsy findings available
Z	<u> </u>		Com			autopsy performed 1 Yes 2 2	
3	/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
To	of	Physicien: this certificatal director,	2	1 ☐ Yes 2 ☑ No Hospital: in Lapatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			6 ☐Other (Specify)
		Jing After fune	tlon	1(☑Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	3d. Describe how in	jury occurred
	Division	Attending r death. sctor: After by the fune	fica	3 Suicide 6 Could not be		3f. Location (Street	and Number or Rural Route Number.
	Ö	after I Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ate)
		ospit hours unere ly fille	sal C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, ar	nd due to the cause	(s) and manner as stated.
		To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	edical	one) and run ner stated.	estigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
		Vith Con	Σ	29b. Signature and title of ce tifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	•		4	((((Mayor) M)	042500		1/24/05
		6	3	30 Name and address of person who completed cause of death frem 23a) (Type 1	TINTO	,	M = 0.0
		Sta	te	31. Date filed (Month, Day, Year) 32. Register's Signature	1 11/2/18		
		Registr		JAN 2 5 2005	Coule		

			For State Registrar	State of	Maryland		artment of rtificate o		and Mental H	lygiene Reg. No.	111116	03	171
	Dhuaiai		1. Decedent's Name (First, Middle	e, Last)				-	2. Date of Month	Death Day	/ Year	3. Time of	Death
	Physicia /Medic		Ronald	С.	Lowe	е			Januar	cy 14,	2005	8:30	рМ
	Examin	er	4a. Facility Name (If not institution	n, give street and numb	oer)		4b. City, Towr		of Death	4c.	County of Death		
			Casey House	6. Sex 7	Ann Ila um la	na himbuta	Rockvil If Under 1 Ye		24 Hrs 0 Date of	Dieth	Montgo		
	Funeral Director		5. Social Security Number 213-56-5466	1⊠M 2□F	. Age (In yrs. Ia 56	Yrs.	Months Day		Min. (Month,	Day, Year)	948 Wash	place (State or ntry)	
	D		Usual Residence of Decedent						0000		740 Wasii.	ingcon	_ 100
	how		10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside Cit	
	Ba-f s	cto		ontgomery					Spring			1 🗆 Yes	2 KI NO
	vith th	Dire	10e. Street and Number				10f. Zip Cod				izen of What Cou	ntry?	
	s 23	era	2028 Seattle Av	12. Was Deced	ant Ever in 11 S	12		20905	igin? (Specify Vos or		J.S.A. 14. Race - Americ	can Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if litem 27 is marked other than "natural", or items 23e or 28e-f show any injury or pather traumatic event, the Madical Exaction matt be mullified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marriad 3 ☐ Widowed 4 ☐ Divorced	ried Armed Force 1 ☐ Yes 2 If Yes, Give	es? !⊠No	i	if Yes, specify C		igin? (Specify Yes or n, Puerto Rican, etc.)	140-	Black, White,	etc.	
21215-0036	2 hou	led	15. Deceden	t's Education			dent's Usual Oc			16b. Ki	ind of Business/In		
215	hin 73	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4	for 5+)	(Give	kind of work do DO NOT use re	ne during mo: ired)	st of working				
21	ad with	Com	2,0,1,0,1,0,1,0,1,0,1,0,1,0,1,0,1,0,1,0,	2	2 (Custor	n Golf (Club Ma	ker	Ret	ail		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)					er's Name (First, Mide	dle, Maiden	Sumame)		
<u>Y</u>	Men Marke marke	ပ္	Harry E. Lowe						1 Kinsley				
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relations						er or Rural Route Nur				. 1
e)	1 and Healt em 2 ther		Peggy Cole / W: 20a. Method of Disposition	ıre	20b. Pla	ace of Dispo	sition (Name of		Silver Spi	_	Mary Land ocation - City or To		,
10	ages in of a		1 ☐ Burial 2 ☑ Cremation		tate F+	metery, crei	natory or other	natory(01/20/05		ntwood, 1		nd
altimore,	artme ortan injur	1	' 4 □ Donation 5 □ Other (S		110.				ty HINES-R				
B	Per limp any gang		4 Ruch	E. W.L.	_	1:	1800 Nev	7 Hamps	shire Ave.	Silve	er Spring	g, MD 2	20904
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	used the death.							Approximate Interval Betw)
	Physician		Immediate Cause (Final disease or condition		relodys	plasti	ic Svndı	ome				Onset and D Months	
	/Medical Examiner	. 1	resulting in death)		r as a conseque								·
	Lxaminer	_	Sequentially list conditions,	b	r as a conseque	cens of a							
	led Isit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2 200 10 (0	r as a consequi	erioe orj.							
	al-trai	xar	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	ence of):					-		
8760,	ate be executed thysician and the burial-transit			d									
9	tificate ng phys as the	fedical	12.55.11.5					-					
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnan		Ectopic pregna	ncy			23d. Date of delive Month	_	ear
0.	e dea the at ned fo	sici	1 Yes 2 No	4□Pregna 9□Unknov	nt at time of dea vn	ath 5	Other (specify)		-	WORTH	Day	oai
Ρ.	that the de led by the a detached		Part II. Dther significant conditi	ons contributing to dea	ith but not resul	Iting in the u	nderlying cause	given in Part	I. 23e. D	d tobacco u	use contribute to t	he cause of de	eath?
Vital Records,	ng ja	d by					1.1 7 1.9			∐Yes 21	⊠No 3 Prot	oably 4 ⊟U	nknown
COL	> 40	Completed							24a. W	as an	24b. Were auto	posv findings a	vailable
Re	The law ate has b page 2 sl	щ						_	at pe	itopsy erformed?	prior to co death?	mpletion of ca	use of
tal	ician: Th certificate rector, pag	Ö	25. Was case referred to medica	d				26. Plac	e of Death (Check on		1 🗆 Yes	2 No	- 202
\leq	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	patient 2 🗆 E	ER/Outpatier	nt 3 DOA		ursing Home 5 R		6 K Other (Specif	Assist	ed
J of		n: T	27. Manner of Death 1. 1. 1. 1. 1. 1. 1. 1	28a. Date of (Month)	Injury , Day Year)	28b. Time o Injury	f 28c. l	njury at Vork?	28d. Describ			22.4.2.14	
Sio	Attending r death. sctor: After	atic	2 Accident investi	gation			M	□Yes 2□					
Division	or Atteno after death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place C	of Injury - At hor g, etc. <i>(Specify)</i>	me, farm, sti	eet, factory, offi	ce		n (Street an Town, State	d Number or Rura)	ul Route Numb	ier,
	Hospital (4 hours al Funeral D tely filled i		On Cartifica 1 TO Continui	an Obviolate To the h	not of mulman		h		and alone and displays	ha asusa(s)	and manner on a	101-1	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 X Certifyii (Check only 2 Medical one)	ng Physician: To the bas Examiner: On the bas and manne	sis of examinati	on and/or in	vestigation, in n	y opinion, de	ath occurred at the tim	ie, date and	place, and due to	the cause(s)	
	To the within 2. To the formplete	Me	29b. Signature and title of certifie	ər			29c. Lic	ense number		29d. Dat	te signed (Month,	Day, Year)	
-	2) 2		1 (While	Janjo.	,		BR4	216114		Janua	arv 16.	2005	
(=	5) >		30. Name and address of person				Print) Chi	ra Raj					
	1925		6001 Muncaster					nd 2085	00				
	Sta Registr		31. Date filed (Month, Day, Year,	2005 32 Re	gistrar's Signate	ure for	de						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 1 Decedent's Name (First Middle, Last) Month Vage Physician 8:45 P M JANUARY 27 2005 RICHARD EUGENE LEWIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**X** M 2□ F June 28, 1940 Maryland 218-38-1366 64 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County item 27 is marked other than "natural", or iteme 23a or 28e-f ahow other treumatic avent, the Medical Executor mant be inclifted at 1 Yes 2 □ No Director Maryland Frederick Frederick 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 1019 North Market Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give 1958-1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify White ð 3 XWidowed 4 ☐ Divorced Year or Dates 1963 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer City Police 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Ruth M. Cross Harold R. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 Kline Boulevard, Frederick, Maryland, 21701 Karen Miss/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: if ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 XOther (Specify) Entombment Mt. Olivet Mausoleum 01/31/2005 Frederick, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility 106 East Church Street Milhan Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 4 DAYS Eso phageal cancel Physician disease or condition resulting in death) /Medical Due to (or as a cons suence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The taw requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed I peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 2 No this certificate 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of filled in by the funeral 27. Manner of Death Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation efter death Director: 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide within 24 hours e To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0059283 JANUARY 28 2004 HOSPITALIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 TH STREET, FREDERICK, MARYLAND ADDO RICHARD M.D. 0 2. Registrar's Signature 0 3 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylan		artment of H tificate of I		R	leg. No.	03173
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	ELEANOR B. LORDITO			4h Oib Ton		01	17 2005	2:45 a. M
	Examin	er	4a. Facility Name (If not institution, give s Washington Advent:			Takoma 1	Location of Death	1	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Director		3//-44-8364	^{M 2} ∑F 91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) June 29,	1913 Peni	nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	v. Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	Ď	Maryland Prince Go	eorge's Hya	ttsvil	16				1 ☐ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	corge s nyu	CCSVII	10f. Zip Code		1	10g. Citizen of What Cou	intry?
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show avant, it e Medical Exartinal result to nailliad at	al D	5612 35th Avenue			20782			U.S.A.	
	tems tems	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
30	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify: Wh:	
Maryland 21215-0036	2 hou	ted t	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business/Ir	·
212	hin 73	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	during most of wor)	king		,
7	filed withi Hygiene. other than ant, ir e M	Completed	12		Admin	istrative			Selective S	Service
D D	d d d d d	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I	11	
Ĕ	should be ind Menta is markad umatic av	5	Edward Vincent Boo		19h Mailin	Address (Street		ella Rit	r, City or Town, State, Zi	n Codel
<u>8</u>	2 E S		Nancy L. Leonard,			22nd P1ac				0782
altımore,	t Health item 27 other tra		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place			20c. Location - City or T	
Ĕ	Pages nent of ant: If it ary or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ivet Cemet		9/2005	Washington	D.C.
gall	permit. Pages Department of I Important: If ite any injury or of once.		21. Sign yur of Funeral Se Ince License						meral Home,	P.A.
n	405 g d		23a Part 1. Enter the disease, or complete						sville, MD	
1	Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final di se or condition resulting in death)	Aspiration Due to (or as a consequence)	neumor		g, such as cardiac	or respiratory arri	est,	Approximate Interval Between Onset and Death
	Examiner	Jer	if any leading to immediate	Cardiac Arrh	nythmia	a				
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Coronary Art		isease				
60,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	•	- •				
68760	physics the t	dlcal	d	Arterial Fib	orilla	clon				
O. Box	tt the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ت. ت	res that igned by be deta	by Ph	Part II. Other significant conditions con-	tributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tot	bacco use contribute to t	he cause of death?
g	w require been sig should b							1 □ Y€	es 2X∑No 3∐Pro	bably 4 Unknown
Hecords,	e la has	Completed				_		24a. Was a autops perforr	med? prior to co	opsy findings available ompletion of cause of
Vital H	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					th (Check only on		
Division of	ding Phys n. After this funeral di	tlon: To	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	ospital: 1 🔀 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Work	at		ence 6 Other (Special Other)	(y)
DIVIS	spital or Attendi ours after death. laral Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or Run n, State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	estigation, in my or	pinion, death occu	and due to the carred at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To To Com	Σ	29b. Signature and title of certifier			29c. License		2	9d. Date signed (Month,	Day, Year)
	W Har		> Struct				998		1/17/2005	
	10		30. Name and address of person who cor				Constant 1	Hance	211 - Am 0	0700
	Sta	ite	Steven T. Tee, M. 31. Date filed (Month, Day, Year)	♠2. Registrar's Signa	ture	Street,	suite I,	нуаttsv	111e, MD 20	0782
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			Registrar				Cé	rtificate of	Death		Reg. No.	000	00114
	- · · ·		1. Decedent's Name (Fir	st, Middle, Last)		_ /		0		2. Date of De		V = 0.5	3. Time of Death
	Physicia /Medic		KOLDERT	Lee!	Varuis	10154	UV	21		TAN/	Day	Year	5:524
	Examin		4a. Facility Name (If not	institution, give s				4b. City, Town,	or Location of Death	1	4c. Co	ounty of Death	0.00
	. LXajiiiii	Ċ,	Washington	Country	Handto			Hoomete					
			Washington 5. Social Security Number			Age (In yrs. la	st hirthday	Hagersto	If Under 24 Hrs.	8. Date of Bir		hington	
	Funeral				M 2□F		Yrs.	Months Days		(Month, Da	v. Year)	9. Birth	place (State or Foreign ntry)
	Director		215-36-6196 Usual Residence of Dec	adant		65				Oct 17,	1939	West	Virginia
	and	1		. County		10c. City.	Town or L	ocation					10d. Inside City Limits
	anyl aho	5											1 ☐ Yes 21 No
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	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or Itams 23s or 28s-f show imatic event. It s Medical Examinet must be notified at	Director	10e. Street and Number					10f. Zip Code			10g. Citizer	n of What Cou	ntry?
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	dea s	Funeral	11. Marital Status		12. Was Decede Armed Force	nt Ever in U.S	13.		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No		Race - Ameri	
ပ္	or Ita	교	1 Never Married	2X Married	1 □ Yes 2					o Hican, etc.)		Black, White,	
9	urs a	þ	3 Widowed 4 🗌	Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2X No	Specify:		Sp	ecify:Whit	:e
P	2 ho	Completed	15.	Decedent's Educ	cation		16a. Dece	dent's Usual Occu	pation		16h Kind	of Business/In	dustry
5	in 72 n" o	olet	(Specify or	nly highest grade	e completed)		(Give	kind of work done DO NOT use retire	during most of wor	king			dustry
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20	filed withi Hygiene. Ither thar ant, Ite M		17. Father's Name (First,	Middle (ast)			TOW P	lotor Dri	18. Mother's Nan	(Fine & Ministr		facturi	ng
Ĕ	Mental Harkad of atic eval	Be										тате)	
No.	should ind Men s marka umatic	ပ္	David	Morning	star				Daisy B.	Johnso	n		
Maryland 21215-0036	2 sho and Is mu		19a. Informant's Name/	Relationship (Ty)	pe, Print)		19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Numb	er, City or T	own, State, Zij	Code)
Σ	25 E Z		Robert L. M	ornings	tar Jr.	/son	17719	Garden	View Rd H	agersto	wn Mai	vland	21740
Baltimore,	is 1 au of Hea itam otha		20a. Method of Dispositi			20b. Pla	ace of Disp	osition (Name of		Date		tion - City or To	
2			1 X Burial 2 □ Cre		emoval from Sta	lle	-	matory or other pla	· I				
Ħ			`4 □ Donation 5 □			Res			ery 1/22		Hager	stown,	Maryland
<u>a</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral	Bervice Ligeries	90	_			ess of Facility Res				
	00 = a 0		-	10	~~		1	601 Penns	sylvania A	Ave Hage	rstow	n Mary	land 21742
			23a. Part1. Enter the of shock, or heart fail	sease, or compli	cations the cau	sed the death.	Do not en	ter the mode of dy	ing, such as cardiac	piratory a	rest,		Approximate Interv I Belw en Ons a and Jeath
	Physician		Immediate Cause (Final		1/ 100	- 1 1	Q.	Š	- N	1/			Onse and Jeath
	/Medical		disease or condition resulting in death)	a		PHIL	470	my 1	U Su V	MICIL	nen		1 PRIVOD
	Examiner				19(0)	asia consequ	T COL	. / 1 .		0.4.00			1 1 1 1 N
	3 30	_	Sequentially list condition	ns b		HEST	UX.	1 Lu	M	evice			12/25/0
	π σ	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	iate	Due to (or	as a conseque	ence of):		1				
	cute nd rans	an	that initiated events	'	s			<					• /
ó,	an a rial-1	EX	resulting in death) Last		Due to (or	as a conseque	ence of):		7				
8760,	Attanding Physician: The law requires that the death certificate be executed rideath. rideath. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be dejached for use as the bunal-transit.	cat			1								
89	ficat g phy s th					_							
×	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	2	3c. If yes, outcor	me of pregnan	CV						
Вох	atter for u	ian	23b. Was decedent preg in the past 12 month	gnant j	1 Live birth	1 2 ☐ Fetal o	death 3	Ectopic pregnanc	ey .		230	 Date of deliver Month 	Day Year
	at the de by the a tached	slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregnan 9⊟Unknowi	t at time of dea	ath 5t	Other (specify) _					,
P.0	at th	5											
	res lha igned l be det	by	Part II. Other significan	conditions	ntributing to deat	h but not resul	ting in the u	inderlying cause gr	ven in Part I.	23e. Did t	bacco use	contribute to t	he cause of death?
Ö	quire n sig		-MA	UNCUIC	12 7	JU	MI	M		142	es 2 🗆 N	lo 3 ☐ Prok	ably 4 Dunknown
#26 Nital Records,	w require been si should b	Completed								24a. Was		Ab More sut-	anny findings available
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10	The cate ha	8								1 🗆 Yes		1 Yes	2 □ No
子び芸	sician: Th certificate irector, pag	Be	25. Was case referred to examiner?						26. Place of Dea	th (Check only o	ne)		
~ -	Physic this co	ို	1 ☐ Yes 2 ☐ No	Н	lospital: 1 🗶 Inp	atient 2 🗆 E	R/Outpatie	nt 3□ DOA Ot	her: 4 \(\text{Nursing H} \)	ome 5 Resid	lence 6	Other (Specif	(y)
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₹5	ding F th. : After s funera	윤	1 ☑Natural 5 [2 ☐ Accident	Pending investigation	(INOTIE),	Day roary	Injury		Yes 2 No				
S	Attandi death. ctor: A y the fu	fice	3 Suicide 6	Could not be	28e. Place of	Injury - At hon	ne. farm. st	reet, factory, office		28f Location /	Street and N	lumber or Rurs	al Route Number,
2	or / after Dira in b	Certification;	4 Homicide	determined	building,	etc. (Specify)		oot, vastery, omoo		City or Tov	m, State)	0.,,00, 0, 1,0,0	ar riouto reamber,
]	To the Hospital or Attanwithin 24 hours after death To the Funeral Director:		One Continue	Carallada a Pi	ilian T		1-4						
	Hos 4 ho Fund ely f	ica	(Check only 2	Medical Examir	ner: On the basi	s of examinate	nedge, deat on and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time.	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
	the tha I	Medical	Olie)	7	and manner	etaled.							
	To To Corr	2	29b. Signature and title	of certifier	1	//	10	1 29c. Licen	se number		29d. Date s	igned (Month,	Day Year)
			A ///	/ Buch	-	111.	116	1 D	5022-	7	1	1171	05
			30. Name and address of	of person who co	ompleted cause	of death (from)	23a) (Tune	Print)		1			
6	4-4		D - V	5 4 4 2	/	21	100	Pr. A	N	n 1	0	2/	
A M			D //	win	//	20 (14ac	Music	/T/	11. 11. d	-31	14)	
			 Date filed (Month: D) 	av Yearl	20 0 20	strar'e Signat.	ire.						
	Sta Registr	- 1	31. Date filed (Month, D	IN 2 0 20	005 32. Red	strar's Signatu	iré Mi	has sto	•	/			

Fund perritt. Paues 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Imp. reant: if Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	For State	State of M	arylan	-	artment of rtificate or				2001	. 00171
	Registrar 1. Decedent's Name (First, Middle,	, Last)				Dealii		Reg ate of Death	. No.	3. Time of Death
	RogeR	Lewis		/	M: LLER		J4	NUARY	20 200	5 12:05P
ř	4a. Facility Name (If not institution,		100	400	4b. City, Town	or Location of		/	4c. County of D	Death
			ge (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Day	r If Under	24 Hrs. la n	ate of Birth fonth, Day, Y	(ear) 9.	Birthplace (State or Foreig Country) IRGINIA
ŀ	Usual Residence of Decedent		00				- SLF	1. 20,	1941 V.	INGINIA
	10a. State 10b. County	LEV	10c. City	y. Town or Lo						10d. Inside City Limit
200	WV BERKE	LEY		MA	RTINSBUR					1 Tyes 2 N
5	10e. Street and Number 112 CALEBS POIN	Т			10f. Zip Code	401		10g	. Citizen of What USA	t Country?
3	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of		igin? (Specify Y	es or No-		American Indian,
	1 ☐ Never Married 2 X XMarrie	Armed Forces?					i, Puèrto Rican	, etc.)		Vhite, etc.
١.	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🗓 N	o Specify:			Specify:	WHITE
4	15. Decedent' (Specify only highest			16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use reti	upation e during mos	t of working	16	b. Kind of Busine	ess/Industry
	Elementary/Secondary (0-12)	College (1-4or	5+)		SERGEANT	rea)			US ARM	ΙY
	17. Father's Name (First, Middle, L	_ast)				18. Mothe	er's Name (Firs	t, Middle, Ma	iden Sumame)	
	RALPH MILLER						VIO	LA BRO	NWC	
ľ	19a. Informant's Name/Relationsh								City or Town, Stat	
	JANA MILLER/SP	OUSE	, .						G, WV 25	
1	20a. Method of Disposition 1 Durial 2 □ Cremation	3 Removal from State	20b. P	lace of Disponenters, cre	osition (Name of matory or other p NN PRESB.	lace)	JNUARY 200	20	c. Location - City	
	' 4 □ Donation 5 □ Other (Sp	ecify)	GER						ERRARDSTO	
	21. Signature of Funeral Service L	icensee Li Geann)	Î.	BROWN FUNE	RAL HOME	, P.O. B	OX 821. MARTIN	327 W. KI	ING ST.,
	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death	n. Do not en	ter the mode of d	ying, such as	cardiac or resp			Approximate Interval Between
dedical Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as c. BRA Due to (or as	dyC	ARd	14					
r II yaleldi i ili	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Feta	Ideath 3	□Ectopic pregnar □ Other (specify)				23d. Date of Month	delivery Day Year
	Part II. Other significant condition	ns contributing to death t	but not res	ulting in the u	anderlying cause	given in Part I	. 2			te to the cause of death? Probably 4. Al-Unknow
								T Tes	2 □ No 3 □	Probably 4Unknow
- Condition	<u> </u>							4a. Was an autopsy performe	d? prior	e autopsy findings availab to completion of cause of h? Yes 2 No
	25. Was case referred to medical examiner?						of Death (Che	ock only one)		
Cel Illication, 10	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending		ury	28b. Time of Injury	of 28c. In	jury at lork?	28d. [ce 6 Other (5 injury occurred	Specify)
	2 Accident investig	ot be Gas Blace of In	iun - At h	ome farm of	M 1 reet, factory, office	Yes 2		ocation (Street	at and Number o	r Rural Route Number,
	4 Homicide determi	building, e	tc. (Specif	y)	reet, factory, offic	Ð		city or Town,		r Hurar Houle ryumber,
	29a. Certifier 12 Certifyin (Check only one) 12 Medical 8	g Physicien: To the best Exeminer: On the basis	of my kno	wiedge, deal	th occurred at the	time, date an	nd place, and d	ue to the cau: the time, date	se(s) and manne a and place, and	r as stated. due to the cause(s)
	29b. Signature and title of certifier	A A	tatou.		29c. Lice	nse number		29d	. Date signed (M	Ionth, Day, Year)
	b landon	Val mu	1201	idan 1-	AU	417/	425 K	524	1-20.	2005
	30. Name a d address of person	completed cause of 32. Regist	death (Iten	n 23a) (Type	Print)	- Rai	(10))	MA 7	1201	
	31. Date filed (Month, Day, Year)	32 Reniet	rar's Signa	ture	Ne Tree	TON	TIMER &	1140	uar/	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 2005 **Physician** JANUARY 1:22 a M Evelyn Joan Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Director Yrs 039-10-1329 87 Oct. 2, 1917 Rhode Island Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23a 21854 Potomac View Drive 20650 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (AVes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be titled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel" or item any injury or other traument. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 3 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Clovis Trembley Eva Gledu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Martin, M.D. / Spouse 21854 Potomac View Drive Leonardtown MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) St. Aloysius Jan. 27, 2005 Leonardtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 1095 22955 Hollywood RD., Leonardtown Maryland 20650 David A. Goff 23a. Part1. Enter the disease, or com shock, or heart failure. List only the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, (lary, localing to minimum) cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of) law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, à LOCIEC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes XXNo 1 🗌 Yes **2** No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 | Yes 2 No 1 Impatient Division of 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifie 29c. License number 0 29d, Date signed (Month, Dav. Year) D60888 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKHI KRISHNAN SHAH ASSOC HOLLYWOOD MD 20636 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

J MARTIN

EVELYN

P.O. Bo
Records,
Vital
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Division

ROBERT DONALD MARTELL

			1 - For State Registrar	State of Mar			of Healtl			iene eg. No.	005	03177	
	.		1. Decedent's Name (First, Middle, Last,)			· ·		2. Date of Dea	th		3. Time of Death	
	Physici /Medio		Robert Donald Ma		Month JANUARY	Day 7 18	Year 2005	7:39 p M					
	Examir		4a. Facility Name (If not institution, give				own, or Locati			4c. County of Death			
			St. Mary's Hospit	:al		Leo	nardtov	√n			St. Ma	ary's	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)		Year If Uno	der 24 Hrs.	8. Date of Birth	(Year)	9. Birth	place (State or Foreign	
	Director		110-20-8970	2M 2U F	69 Yrs.			10	3-20-13	935′	New Yo		
	and *		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	cation						10d. Inside City Limits	
	Aanyl sho	ō	Maryland St. Mary's Leonardtown										
	28e	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh									into/2	
	With Sa or	i		" 010					1				
	ms 2	Funerai	22810 Dorsey Stre	12. Was Decedent Ev		Was Decedent of Hispanic Origin? (Specify Yes			ecify Yes or No-	United States or No- 14. Race - American Indian,			
ထ	of Ital	Für	1 ☐ Never Married 2 ♣ Married	Armed Forces? 1 1 Yes 2 □ No If Yes, Give	1955-	If Yes, specif	y Cuban, Mex	tican, Puerto	Rićan, etc.)		Black, White,	, etc.	
03	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2	No Spec	cify:		S	Specify: Wh:	ite			
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-f show ta Madical Exami at marter rollified at	Completed	15. Decedent's Edu (Specify only highest grad		/Give	dent's Usual	done during n	most of worki	ina	16b. Kind of Business/Industry			
21	nithin ne. han	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)						
	filed withi Hygiene. othar than ant, the M			12 Mortgage Brok							Financial		
and	ould be fi Mental H wark ad otl	Be	17. Father's Name (First, Middle, Last) Francis Martell				18. M		eline Gu		umame)		
2	should nd Men marka umatic	2	19a. Informant's Name/Relationship (T)	one Drintl	405 14-10		2011		I Route Number		- 0 -		
Maryland	O1 62 65 50		Dawn M. Shade/ Day						ng Road,				
	1 and 2 Health tam 27 other tra		20a. Method of Disposition		20b. Place of Dispo	sition (Name	e of		Date	20c. Loca	ation - City or T	Own, State	
ο̈́	Pages nent of h ant: If its ary or o		1 ☐ Burial 2X Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		cemetery.cres Brinsfiel	-					otte Ha		
Baltimore,	7 5 4 5		21. Signatur uneral Service Clorus		1			Jan.	40.U0			-	
Ba	Depared Impou		Edward N. Brinsfie	ld, Jr. N	100052 2	2055	Hollyman	Bri	nsfield ad, Leor	Fune	eral Hon	me, P.A.	
			23a. Part1. Enter the disease, or comp	ications that caused th							.OWII, FII	Approximate	
	Physician		Immediate Cause (Final Shock, or heart failure. List only one cause on each line.										
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	,							
	physician and military is the burial-transit		Conventially list conditions	Mult	i aral fo	ailure	2						
		ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury										
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90,	oe execian sourial	Ü	resulting in death) Last	Due to (or as a	consequence of):	4	6	Ible	e d				
8760,	physicate to the control of the cont	dicai		d	- hypoti	4)100							
9		/Me	IF FEMALE:	23c. If yes, outcome of	nregnancy								
Вох	death certif e attending id for use as	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day		,			
P.O.	0 0 9	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	0. 4044.	3 0(1)01 (3)00	ony/						
٦,	The law requires that the ste has been signed by th bage 2 should be detache	by Physician/Me	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying ca	use given in Pa	art I.	23e. Did to	bacco use	e contribute to t	the cause of death?	
Records,	quires n sign				1 ☐ Yes 2 ☑ No 3 ☐ Pt			bably 4 Unknown					
00	aw requir as been s 2 should	olete						24a. Was an 24b. Were			opsy findings available		
Re	The lay te has age 2	Completed							autops	ned?	prior to co death? 1 Yes	ompletion of cause of	
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f V	Physician: this certific ral director,	To B	examiner?	lospital: 1 Inpatient	2 ER/Outpatier	Othor			me 5 Residence 6 Other (Specify)			fy)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	28	c. Injury at Work?		28d. Describe ho				
<u> </u>	Attanding ir death. actor: After by the fune.	atic	2 Accident investigation	, , , , , , , ,	M 1 Yes 2 No			2 □No					
Division	I or Attandi after death. Diractor: A I in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	eet, factory,	office		28f. Location (St City or Town	tion (Street and Number or Rural Route Number, or Town, State)					
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	To the Hospital or Attand within 24 hours after death To tha Funarel Diractor: completely filled in by the	Medicai	(Check only 2 Medical Exam)	sician: To the best of ner: On the basis of e	xamination and/or in	h occurred a vestigation, i	t the time, date n my opinion,	e and place, a death occurr	and due to the ca	ause(s) ar ate and p	nd manner as s lace, and due t	stated. o the cause(s)	
	thin S tha tha mple	Med	one) 29b. Signature and title of certifier	and manner state	90.		29c. License number			29d. Date signed (Month, Day, Year)			
								9475	-	1 /	signed (Month, Day, Year)		
	SNO		30 Name and address of person who	omploted source of d	U - / 6)	Print)	10000			(/	170	,	
	3		30. Name and address of person who compared MEHRDAD AKHLAGHI				ADDMOTT	N 100	00650				
	Sta	ite	31. Date filed (Month, Day, Year)	ST. MARY	S HOSPITA s Signature	L LEON	AKDTOW	N MD	20650				
	Regist		JAN 2 5	ZUUD DE	Organ All	Bank	18						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 11:35 25, Rita Wise Martin January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center <u>Solomons</u> Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 💢 F 91 Yrs. Director 198-10-9603 October 21, 1913 Maryland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 17 is marked other than "naturel", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2XXNo Maryland Saint Marys Leonardtown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 22680 Cedar Lane Court, Apt. 3302 death v by Funeral 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Medical Examinar sonce. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Paul Wise, Sr. Susan Bertha Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Ewing / Daughter 8209 Danbury Drive, Norfolk, Virginia 23518 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date January 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Cemetery 29, 2005 Leonardtown, Maryland 21. Sign wure of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongeslive Physician ilure rew /Medical Due to (or as a conseque of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit certificate be executed that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 1 Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: director 25. Was case referred to medical examiner? Be 26. Plac of Death Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2/1 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral Natural her of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19427 2005 0 Allen M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar Munshi, M.D. 110 Hospital Road, Prince Frederick, Maryland 20678 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 8 2005 Registrar

		_	For State Registrar	State	of Marylar		artment of tificate of				ene g. No. 20	05	03180
	Physici /Medic		1. Decedent's Name (First, Midd Ruth R.Martin	le, Last)					, A	oate of Death Month	Day 18, 20	Year 05	3. Time of Death 12:13 a. M
I	Examin		4a. Facility Name (If not institution Kline Hospice	4b. City, Town, Mt. Air			4c. County of Death Frederick						
	Funeral Director		5. Social Security Number 216-22-8835 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Yea Months Days		Min. (/	eate of Birth Month, Day, ch 28		Coun	lace (State or Foreign try) yland
Maryland 21215-0036	Maryland fed at	į l	10a. State 10b. Count	erick		ty, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2X No
	3a or 28a	i Director	10e. Street and Number 9422-B Dublin Road				10f. Zip Code 21793		Og. Citizen of What Country? U.S.A.				
	be filed within 72 hours after death with the Marylar Hygiene. da Hygiene. da chher than "natural; or Items 23a or 28a-f show acher than "natural; or Items 23a or 28a-f show avent, the Medical Examination must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				Was Decedent of f Yes, specify Cu			Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: white		
	within 72 ho iene. • than "natur the Medical	Completed	(Specify only highest grade completed) (Given black properties of the complete (Given			(Give life. L	dent's Usual Occi kind of work don DO NOT use retir	et of working	1	16b. Kind of Business/Industry Own home			
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<u> </u>	ges 1 and 2 should be file t of Health and Mental Hy If item 27 Is marked oth or other traumatic event	²	Ellis O. Ramsburg						hristin			0	
	nd 2 sh lith and 27 is n r traun	1 4	19a. Informant's Name/Relation Rena Shry —	sister			g Address <i>(Stree</i> N. Mark						
Baltimore,	ges 1 al t of Hea if item or othe		20a. Method of Disposition 1 Description 1 Description 1 Description 2 □ Cremation			Place of Dispo	sition (Name of natory or other pi	1	Date		Oc. Location -		
Ħ H	permit. Pages Department of Important: If it any injury or o		`4 □Donation 5 □ Other (Specify)			Memoria		-21-200				aryland
Ba	permii Depar Impor any ir		21. Signature of Funeral Service	Licensee	Colle		. Name and Add		Dead		Funeral		
	Physician /Medical Examiner purishtysician and purish transit the price transit transi	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cause Interval Between Onset and Death Cause. Service Part Cause. Due to (or as a consequence of):										
P.O. Box 687	death certific e attending p d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live 4 □ Pre 9 □ Unk		al death 3 ☐ death 5 ☐	Ectopic pregnan				Mor		Day Year
ds,	uires ti n signe	d by	Part II. Other significant condit	COMBO			239. Did tob 1 □ Ye	obacco use contribute to the cause of death? Yes 2 2 No 3 Probably 4 Unknown					
al Recor	: The law requires that the cate has been signed by the page 2 should be detache	Completed								24a. Whas an autopsy perform	ed? d	rior to con eath?	psy findings available npletion of cause of 2 No
Division of Vital Records, for Attending Physician: The law requires t	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag	Certification: To Be	examiner? 1 Yes 2 You Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify Kline Ho								,		
N N	oital or Attendurs after deatl oral Director: illed in by the		4 Homicide deter	bui	ding, etc. (Spec	ify)				City or Town,	State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	Vill Sor	M	29b. Signature and title of certifi	er	2			032	171	29	d. Date signed	(Month, L	
	(20)		30. Name and address of perso				•	600 P		5	279	ς	
	Sta Regist		31. Date filed (Month, Day, Yea	0 2005 32.	Registrar's Sign	ature	Lock	-01-25-01					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 4 UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Morris Ralph January 17, 2005 1943PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland hospital Clinton Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 21,1936

8. Birthplace (State or Foreign Country)
Washington DC Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ★M 2 ☐ F 68 577-52-5887 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5002 Brookdale Ct. 20772 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Coffege (1-4or 5+) Food Clerk Grocerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles E. Morris Mary Reilev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Barbara L. Morris (Wife) 5002 Brookdale Ct. Upper Marlboro, Maryland 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 24, 1 Buriaf 2 ☐ Cremation 3 ☐ Removal from State injury o * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Brentwood, Maryland 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in Lee Funeral Home, Inc. M01340 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6633 Old ALexandria Ferry RD Clinton. 20735 Approximate Interval Between Immediate Cause (Finaf **Physician** MECLYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 1 Yes 2 ₺ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of fnjury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINGSTON agistrar's Signature State 0 2005 Registrar

		State Registrar 1. Decedent's Name (First, Middle, La)		Certificate of		2. Date of Death	No2005	03 8 / 3. Time of Death
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mine		4a. Facility Name (If not institution, giv Anne Arundel Me			r Location of Death Annapolis		4c. County of Dea Anne	m Arundel
ral tor		173-10-3441	You off a	day) If Under 1 Year Months Days		B. Date of Birth (Month, Day, Ye Jan. 16,	9. Bir 1915 Mi	thplace (State or Foreig punity) nnesota
TEN SI	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel 10c. City, Town		napolis			10d. Inside City Limits
LIN WELLER LEAD HINT THE LY LY HALL WA	al Director	10e. Street and Number 84 Old Mill Botto	m Road North	10f. Zip Code	21401	10g.	Citizen of What Co	•
	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ₩No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify:	
	ieted	15. Decedent's E (Specify only highest gra	ade completed) (Decedent's Usual Occup Give kind of work done i life. DO NOT use retired	nation during most of working	16b	o. Kind of Business	/Industry
	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	5+ Ag	ricultural		Fe	ederal Go	vernment
	To Be	Jens P. Miller			Helga Ju			
		19a. Informant's Name/Relationship (Margaret Wolff/		Mailing Address <i>(Street</i> 07 Marshall			ity or Town, State, . Marylan	
		20a. Method of Disposition P⊆Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2) 21. Signature of Funeral Service Licer	Removal from State Rehobot	Disposition (Name of crematory or other place have place) Pres. Cent 22. Name and Address 147 Duke of	n. 1/18/2 ss of Facility Joh	2005 We	estover, lor Fune	Maryland ral Home
1	ical Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the death. Do no one cause on each line. a. Congestive Hea Due to (or as a consequence of c. Due to (or as a consequence of c. Due to (or as a consequence of d.	rt Failure	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death Years
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	1		23d. Date of de Month	ivery Day Year
	ک	Part II. Other significant conditions of Atrial Fibrill	contributing to death but not resulting in tation	he underlying cause giv	en in Part I.		_	the cause of death?
	Completed					24a. Was an autopsy performed 1 Yes 2 X	prior to death?	stopsy findings available completion of cause of 2 \(\text{No} \)
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ②□No	Hospital: 1 ☐ Inpatient 2 🛣 ER/Outp	eatient 3 DOA Oth	26. Place of Death (e 6 ☐Other (Spe	-4.1
	-	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tir (Month, Day Year) Inju	me of 28c. Injury	4 Li Nursing Homi	e 5 Hesidence		uny)
	Ħ	3 ☐ Suicide 6 ☐ Could not b		n, street, factory, office	28	f. Location (Street City or Town, St	t and Number or Ru tate)	ural Route Number,
	Certificati	4 Homicide determined						
	edical Certification:	29a. Certifying Ph	sysician: To the best of my knowledge, niner: On the basis of examination and/and manner stated.	death occurred at the tin or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause I at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
5	Medical Certificat	29a. Certifier (Check only 2 Medical Exar	niner: On the basis of examination and/	death occurred at the time or investigation, in my of the control	pinion, death occurred	at the time, date	e(s) and manner as and place, and due Date signed (Montal)	to the cause(s)

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month P_M Ronald P. Magrum January 12, 2005 9:59 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bowie Health Care Center Bowie Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/13/1939 Birthplace (State or Foreign Country) 1**X** M 2□ F Director 217-36-8795 65 Yrs. Washington, D.C Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shov Examiner must be confilled at Director N☐Yes 2☐No Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15613 Powell Lane 20715 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 157-163 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If item 27 Is marked other than 1ry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Safe Technician Bank Lock Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul G. Magrum Anna Mary Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Magrum/ Wife 15613 Powell Lane Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. 01/18/2005 Waldorf, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 22. Name and Address of FacilityRobert E. Evans Funeral Home 21. Signature of Funeral Service Licensee - C-K 16000 Annapolis Road Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Antery Disease Astructive Pulmonary Disease onana disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Mel Be Completed 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed2 1 🗌 Yes 2**3**No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. | Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral L 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anong MD 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, MD 14300 Gallant Fox Lane Bowie, MD 20715 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registrar

			For State Registrer	State of Maryland		artment of F		Mental Hy	giene	200=		
			Decedent's Name (First, Middle, Last)					2. Date of De	eath f	4000	3.1	ne of Death
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	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	av. Year)	Co	ountry)	tate or Foreign
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th the	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?	
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affer affer	d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,,,,		City or To	wn, State)			,
DIVISION OF VITAL INCOMES, T.O. BOX 001. To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.	To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Physic (Check only one)	r: On the best of my known: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	n occurred at the time restigation, in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cau	use(s)
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	Funeral Director		5. Social Security Number 215-18-8624 Usual Residence of Decedent	6. Sex 1 ☐ M	2 💢 F	Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb 18	th ly, Year) 3, 19	20		ace (State or I	Foreign
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36	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or items 23e or 28e-f show event, the Medical Exertifier must be notilised at	by Funeral Director	1 Never Married 2 Ma 3 Widowed 4 Divorce	ried	Armed Force 1 Yes 2 If Yes, Give Year or Date	∍s? No		fYes, spec 1 ☐ Yes		n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, V	Vhite, e	tc.	
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Vit.	Physicien: T rthis certifical ral director, p	Be c	25. Was case referred to medic examiner?	Hos	pital:		leno		Othe	100		(Check only o					
ō	ding Physicien: After this certific funeral director,	n; To	1 ☐ Yes 2 🕱 No 27. Manner of Death		1 ☐ Inp 28a. Date of (Month,		ER/Outpatier 28b. Time o		28c. Injury Work	4 DE NU		me 5 Residence R			Specify)		
ion	tanding leath. tor: Afte the fun	atio	2 1 1 100 10 0 1 1 1	igation	(Month,	Day Year)	Injury	м		<br Yes 2□	No						
Division	i or Attan after deatl Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	not be mined	28e. Place of building	Injury - At h , etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory	y, office			28f. Location (: City or To			r Rural	Route Numbe	er,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune.	Medical C	29a. Certifier 1 Certify. (Check only one) 1 Medica	ng Physici I Examiner	ian: To the bas On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date ar oinion, dea	id place, i	and due to the ed at the time,	cause(s) date and	and manne I place, and	r as sta due to t	ted. the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certific	er	0 /	1	Nap. s. ot	290	c. License	number			29d. Dat	e signed (M	onth, D	ay, Year)	
)			Yloleuto	wo (1.10	ren/	M	1	0-	148	36	5	JAN	29.	X ,	2005	
	10		30. Name and address of person	who come													
	Sta Registi		Robustiano Ba	arrera 2005	M ₃₂ D	jistrar's Signa	Mem.	Hosp	Med	d Bldo) Cu i	mberlan	id M l	215 0)2-		

ended_#			partment of Health and Mental Hygiene ortificate of Death
Physicia		1. Decedent's Name (First, Middle, Last) Sigrid May	2. Date of Death Month Day Year January 13 2005 6:05 P
/Medica Examine		4a. Facility Name (If not institution, give street and number) Bowie Health Center	4b. City, Town, or Location of Death Bowie Ac County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 125-38-2455 1 M 2 TF 71 Yrs.	
aryland ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	4784 27
with the Marylan a or 28e-f ehow	Director	MD Prince George's Bowie 10e. Street and Number 12411 Melling Lane	10f. Zip Code 10g. Citizen of What Country? 20715 USA
DESIGNOTE, INISTY STATE A LATE SHOWS permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Heelth end Mental Hygiene. Importent: If Item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumetic event, Ire Madical Exertifier mat be notified at once.	by Funeral		. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: Specify: White
Saltimore, Maryland ZIZIO-UU30 semit. Peges 1 and 2 should be filed within 72 hours eft Department of Heelth end Mental Hygiene. mportent: If Item 27 is marked other then "natural", or nny injury or other traumatic event, tre Madical Expri	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) 16b. Kind of Business/Industry
IGNO A	To Be Co	17. Father's Name (First, Middle, Last) Jakob Peter Armin Keutzer	diologist Medical 18. Mother's Name (First, Middle, Maiden Sumame) Elisabeth Mathilde Berta
and 2 shou and 2 shou beelth end M n 27 is mer traumet		Jackie Rickers-Atkinson / Dau. 4802	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Riverton Lane Bowie, MD. 20715
LIMORE Peges 1 thent of H tent: if iter		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Lakemont	Date 20c. Location - City or Town, State ematory or other place) Mem. Gardens 01-17-2005 Davidsonville, MD.
Dermit Depart impor any ln		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not expected the death.	^{22. Name and Address of Facility} Beall Funeral Home 512 NW Crain Hwy. Bowie, MD. 20715
ate be hysicie	dicai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	interval Between Onset and Death Junediati
that the death certification by the attending for the attending for the asset of the attending for the asset of the asset	by Physician/Me		□ Ectopic pregnancy 23d. Date of delivery Month Day Year
w requires that been signed be should be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
The law re	Completed		24a. Was an autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 🕍 No
SION OT VITA tending Physician: leath. tor: After this certific the funeral director.	Certification; To Be (25. Was case referred to medical examiner? 1	26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \frac{1}{2} \text{ widence 6 Other (Specify)} of 28c. Injury at Work? M 1 \subseteq Yes 2 \subseteq No
DIVI	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
within Compl	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
		30. Name address of person who completed cause of death (Item 23a) (Type 200 H WOLAN 3900 Grown in	01051651A 1/14/05 a. Print) Ave NW Perm6236 Washington, DC 20327
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** SIR 36-2009 4c. County of Death 2:05PM 4b. City, Town, or Location of Deeth а /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Long View Nursing Home Manchester Carroll If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) , Funeral 1□M 2XF Months Days 76 168-22-3743 Dec. 19, 1928 Director Pennsylvania Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23e or 28e-f show Carroll 1 ☐ Yes 2X No MD Manchester Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3332 Main St. 21102 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1X Yes 2 □ No Specify: Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å end Mental Joseph McKeegan Ruth Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i James P. Mills 3095 W. Clearview Dr., Glen Rock, PA 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō Jan. 29, permit. Pegas Department of Important: If it any injury or o 1 N Burial 2 □ Cremation 3 N Removal from State Zion Lutheran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Glen Rock, PA 2005 21. Consture of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Alat hencer's seese / lear 1 **Examiner** Due to (or as a consequence of) Examine ettending physician and for use es the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): resulting in death) Last Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Dld tobecco use contribute to the ceuse of death? 1 Yee 2 → No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? s certificate has t director, page 2 s 212No 1 Lives 2 No ALL Yas funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) မှ 1 ☐ Yes 2 ☐ NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1-Natural i Birector: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours a To the Funeral C completely filled 29a. Certifier 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

2111

32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

30. Name and eddress

31. Date filed (Month, Day, Year)

Feren

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2005

			For State	State of M	•	artment of Health a		/11115	03188
	£		Registrar 1. Decedent's Name (First, Middle,	Last)		ranoate of Death	2. Date of Deati	ng. No.	3. Time of Death
	Physicia						Month January	Day Year 20, 2005	
	/Medic Examin		John J. 4a. Facility Name (If not institution,	O'Grady		4b. City, Town, or Location of		4c. County of Death	8:25 p.m.
1	Examin	EI	St. Mary's l	1600		Leonar	dtown	St.	Mary's
	Funeral			6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year If Under			nplace (Stete or Foreign untry)
	Director		013-05-1719	1 2 M 2□F	90 Yrs.	Months Days Hours	Jun. 19	,1914 Mass	achusetts
	pc .		Usual Residence of Decedent		10c. City, Town or L				10d. Inside City Limits
	shov	_	10a. State 10b. County		Toc. City, Town of E	SCARIOTI		3	1 ☐ Yes 2 No
	8a-f	Director	Maryland St. 10e. Street and Number	Mary's		Hollywood	14	og. Citizen of What Cou	
	with t	급				·			
	s 23	eral	24185 Grate:	ful Way 12. Was Decedent	Ever in U.S. 13	Was Decedent of Hispanic Ori		United St.	
	ter d	Funeral	1 Never Married 2 Marrie	Armed Forces?	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)	Black, White	, etc.
39	ars af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: Whi	te
21215-0036	J within 72 hours after death with the Maryland jiene. The market of tems 23e or 28e-f show the Medical Examiner must be notified at	ted	15. Decedent's		16a. Dece	dent's Usual Occupation	et of working	16b. Kind of Business/l	ndustry
218	within 7 ene. than "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	I of Horking		
2	filed withir Hygiene. Ither than	Son	12		Res	staurant Manag		Restaur	ant
nd	d tal	Be	17. Father's Name (First, Middle, L.			18. Mothe	er's Name (First, Middle, A	Maiden Sumame)	
Maryland	should be nd Mental marked o	ဥ	John O'Grad				izabeth Malo		
<u>lar</u>	0 0 0 m	i	19a. Informant's Name/Relationsh			ng Address (Street and Number			
	s 1 and 2 of Health item 27 i		Mary Josephine 20a. Method of Disposition	O'Grady / V	Wife 24185 20b. Place of Disp	Grateful Way		Maryland 2 20c. Location - City or 1	
Baltimore,	of a		t Burial 2 ☐ Cremation		cemetery, cre	matory or other place)			
Ęï	permit. Pag Department Important: any injury o		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service		St. John	s Cemetery 1			
Ba	permit. Pag Department Important: I any injury c		Cara k	2			Brinsrieid		
			23a. Part1. Enter the disease, or o	sfield, Jr.	M00052 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2955 Hollywood ter the mode of dying, such as	cardiac or respiratory arre	ardtown, Mi	Approximate
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each	ine.	Tomas En Day	2.01		Interval Between Onserand Death
	Pnysician /Medical	ľ l	disease or condition resulting in death)	aPue to (or a)	s a consequence of):	ou tans			day
	Examiner			60010 (01 43	SEA TO	omes.			iveals
	1/150	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sue to (or an	s a consequence of):				1
	cuted od ransit	Examine	that initiated events	c	1 neu	monea			3mbs
0	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as	s a consequence of):				*,
8760,	ate he	dlcal		d					
9	leath certifica attending ph	Med	IF FEMALE:	23c. If yes, outcome	o of orognopou				
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliment	very Day Year
o.	at the de by the a stached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death 31				
σ.	es that tigned by		Part II. Dther significant condition	ns contributing to death	but not resulting in the	underlying cause given in Part I	. 23e. Did tob	pacco use contribute to	the cause of death?
of Vital Records,	uires n sign lid be	d by		\$ 1			1 🗌 Ye	s 2 ∰No 3 ∏ Pro	obably 4 Unknown
00	w require been signature should b	Completed	Malin	nant Hil	isouton	No small	24a. Was ar		topsy findings available
Re	The lav	mo	-	1) surry	autops perform	y prior to c ned? death? 2 No 1 ☐ Yes	ompletion of cause of 2 Mr No
ta		a	25. Was case referred to medical			26. Place	e of Death (Check only one		2,43110
>	Physician: this certificated rail director, I	To B	examiner? 1 ☐ Yes 2 ∰No	Hospital: 1 Inpati	ient 2 ER/Outpatie	nt 3□ DOA Other: 4 No	ursing Home 5 Reside	nce 6 Other (Spec	rify)
	- E		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. Time (ay Yeer) Injury	of 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sio	uttendii death. ctor: A y the fu	catl	2 ☐ Accident investig	nation leading		M 1 Yes 2			
Division	or Attencater death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200, Flace Ut II	njury - At home, farm, si etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Sti City or Town	reet and Number or Ru. I, State)	ral Houte Number,
	pital ours a eral C		29a. Certifier 1@ Certifying	a Physician: To the bes	t of my knowledge, doe	th occurred at the time, date an	ad place, and due to the ea	uso(s) and manner as	etatad
	24 hg 24 hg Fun etely	Medical			of examination and/or is	nvestigation, in my opinion, dea			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	0 #	1	29c. License number	25	9d. Date signed (Month	n, Day, Year)
	10 0		1	art la	MEDEN	1) D M64	119	1-21-0	0.5
	SAE		30. Name and adgress of person v	who completed gayse of	death (Item 23a) (Type	, Print)	-		
	0		J. Patrick Jan			e Notch Road,	Hollywood,	Maryland 20	0636
	Sta		31. Date filed (Month, Day, Year)		frar's Signature	Boards)			
	Regist	rar	UPIN	N U	7 7 7				

			1 - For State Registrar		aryland / Depa	artment of F rtificate of			ene g. 40.05	03189
	Physici	an	Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	n Day Year	3. Time of Death
	/Medi		KENNETH	P	OAKS,	SR.		January	18, 2005	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ath
			926 Salem Aven	ue		Hager	stown		Washing	gton
	Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
	Director		216-26-7822	∑ M 2□F	65 Yrs.			April 10		rginia
	pur 🛌		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion				
	sho sho	7		erson	•					10d, Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	ctc		erson	Harpers					
	vith t	by Funeral Director	10e. Street and Number	_		10f. Zip Code		10	g. Citizen of What C	
	ath v	rai	RT. 2, BOX 77			25425				States
	tem de	une	11. Marital Status	12. Was Decedent if Armed Forces?		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or f	Ϋ́F	1 Never Married 2 Married	1 TYYes 2 □ N If Yes, Give	lo	1 ☐ Yes 2 🖫 No	Specify:		Specify:	White
215-0036	within 72 hours after death with the Maryland ene. than "natural", or frems 23a or 28a-f show ta Medical Exstrict armust be notified at	d b	3 ∏Widowed 4 □ Divorced	Year or Dates:						
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Ž	d Me nark natio	T _o								
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or flems 23e or 28a-f show other traumatic event, I're Medical Exercities mail be notified at		19a. Informant's Name/Relationship (City or Town, State,	
	fealt fealt sm 2 ther		Shirley A. Oaks 20a Method of Disposition	/ Daugnter			y Ave./ H		<u> </u>	
0	Pages nent of H int: if ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	natory or other plac	се)	Date	Oc. Location - City of	r Town, State
Ę.	tmen tant:		'4 □Donation 5 □ Other (Specification)		Frederic			/2005 F	rederick,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Licer	see /	-) [2. Name and Addre			Funeral Ho	
	0 D = 4 O		Soymond C	elers	\sim 1	621 Oposs	sumtown P	ike/ Fred	derick, MI	21702
	Physician /Medical Examiner		23a. Part 1. Erher the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not entre.	ANC &		or respiratory arres	st,	Approximate Interval Between Onset and Death
0,	cate be executed obtaining and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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9	ntifica ng ph as ti	Aed	IE EENALE.							
P.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	quire n sig uld b	pe pe						1 ☐ Yes	s 2□No 3□P	robably 4 Unknown
00	s bee	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	he la e ha: ige 2	mc						autopsy perform	ed? prior to death?	completion of cause of
a		e Cc	25. Was case referred to medical						ZNo 1 □ Yes	s 2 No
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of	ding Phye	I	27. Manner of Death	28a. Date of Injur	y 28b. Time of	IL 3L DOA	4 Nursing Ho	me 5 Residen	viniury occurred	ughters Residence
on	ding th. Afte	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c, Injur Wor	rk? Yes 2 □ No			
Division	f or Attending after death. Director: Afte I in by the fune	fica	3 Suicide 6 Could not be		ry - At home, farm, str			28f. Location (Stre	eet and Number or R	ural Route Number.
<u>S</u>	or A after Direct	Certification:	4 Homicide	building, etc	. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of the basis of and manner sta	of my knowledge, deatle examination and/or in ted.	n occurred at the tirvestigation, in my o	me, date and place, ppinion, death occurr	and due to the cau red at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certified			29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)
) muse	MAIL	aw	0101	-04145	0 (01-20	-05
(5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type			C	1 20	
			Nicholas W Gei) 1870	Amhers	St St. SI	eF. WI	inchesk	er.VA
	Sta	te	31. Date filed (Month, Day Year)		r's Signature	Snooth)			_ , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month January 14, Josephine Payne 2005 9:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Hospital Center Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08-17-1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X X Director 80 231 36 2726 Bedford, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location wohe 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, the Medical Erand, an unsal to multiput at Prince Georges Capitol Heights KXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4015 Will Street 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status fited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2, ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Alfred Payne Ferris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Patricia Irby Daughter 4015 Will St., Capitol Hghts., MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö <u>=</u> 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 01/22/2005 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th St., NE Washington, DC 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician ned for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4-Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier relic, D0026024 January 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, MD 6490 Landover Road, #F Landover, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Valerie Pearson January 13, 2005 4:04 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1213 Granada St. Accokeek Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🖺 F Director 49 151-50-0382 31, 1955 Massachusetts July Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Director Prince Georges Accokeek 1 XYes 2 No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code with or Itams 23a 1213 Granada St. 20607 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after or Hygiene "Hygiene" other than "neturel", or Iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black þ 1 ☐ Yes 2√☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 6 Gov t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Fint: If item 27 Is marked of Harry P. Jones Dorothy McKain 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre James E. Harrison Jr./Fiancee 1213 Granada St. Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery Jan. 20, 2005 Orange, New Jersey 21. Signature of Funeçal Service Licensee 22. Name and Address of FacilityJohnson & Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ensis disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Necwyn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ublime lerouyosarcang burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to/medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 70 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 P.O. I Records, Division of Vital To the Hospitel or Attending Physician: death. Director: hin 24 hours after the Funeral Direct within 24 ho To the Fun completely

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

4 | Homicide

29d. Date signed (Month. Day, Year)

no completed cause of death (Item 23a) (Type, Print)

Medical

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/Media		Elizabeth O. Pro	ofe					January		4:30 a M
Examir	ner	4a. Facility Name (If not institution, g		•		4b. City, Town, o	or Location of Death		4c. County of Dea	ath
		Wilson Health Ca					ersburg		Montgom	ery
Funeral			Sex 1 □ M 2 🔀 F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
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yland		10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
Mar Mar	tor	Maryland Mon	ntgomer	v	Silver	Spring				1 ☐ Yes 2 ➡No
If I'U Z Z 13-UU30 be filed within 72 hours atter death with the Maryland tal Hyglene. d other than *neturel', or tiems 23a or 28a-f show event, ire Madical Exaction must be notified at	Funeral Director	10e. Street and Number		4		10f. Zip Code		10	g. Citizen of What C	ountry?
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r dea	Iner	11. Marital Status	12. Was D Armed	ecedent Ever in Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
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partitione, interview A 12 13 1000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury openher traumatic event, the Modest Examination at the notified at once.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street			City or Town, State,	
nd 2 st alth and 27 is n r traun		Anthony A. Sario	dakis/A	ttornev					le, MD 20	
ten frage		20a. Method of Disposition		20b	. Place of Dispo	osition (Name of matory or other pla		Date 2	20c. Location - City o	
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ر		30. Name and address of person wh	o completed c	ause of death (I	tem 23a) (Type.					
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			For State Registrar	State of M	larylan		artment o			Mental Hygi	ene g. No. 005	03193
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		Registrar		Certificate of Death		g. No U U 🕽	13/94
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Extending the rottlifted at	-	19a. Informant's Name/Relationship (7)	ype, Print) 19b.	Mailing Address (Street and Number or I	Rural Route Number,	City or Town, State, Zi	ip Code)
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be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of	of):			
e be ex	a		d				
The Collads, F.C. BOX 001 The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	lcian/Medic						
andin use	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 C Estado		23d. Date of deliv	very
death death d for	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
of the ache	Physi	9 Unknown	9□ Unknown				
s tha	by P	Part II. Other significant conditions co			23e. Did tob	acco use contribute to	the cause of death?
quire quire n sig uld b		Confertine	Least failure		1 🗆 Ye	s 2 No 3 Pro	bably 4 @Unknown
law requires that some as been signed 2 should be	Completed	Den	entro-		24a. Was ar	24b. Were aut	opsy findings available
he la e ha	E				autopsy perform	prior to content to c	opsy findings available ompletion of cause of
VICAL ician: T certificat rector, pa	Ö	25. Was case referred to medical		26 Place of D	eath (Check only one		215 140
/siciu	0 B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other		nce 6 Other (Spec	ifv)
er this	J	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury at	28d. Describe ho		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
of tun	atio	1 Natural 5 Pending 2 Accident investigation	(MOIIII, Day real)	njury Work? M 1 □ Yes 2 □ No			
ONVISION OF VITAL To Attending Physician: after death. Director: After this certification by the funeral director.	ertification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of injury - At nome, far	rm, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui	ral Route Number,
al or all	ert	4 Hornicide	building, etc. (Specify)		City of Town	, State)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical C	(Check only 2 Medical Exam	iner: On the basis of examination and	, death occurred at the time, date and pla d/or investigation, in my opinion, death oc			
the I hin 2 the I	Med	one)	and manner stated.	29c. License number		d. Date signed (Month	
M. To	-	29b. Signature and title of certifier	eper MD.	D0054636	29		, way, rodi/
-			/			1/19/05	
(9)		30. Name and address of person who o			. 1 . 7 01=	0.1	
				nue, Frederick, Mar	ryland 217	01	
St Regis	ate	31. Date filed (Month, Day, Year)	2005 32. Registrar's Signature	Brooks			

		1	For State Registrer	tate of Maryland		artment of H		nd Ment		ene 0 0	5	0319	15
			Decedent's Name (First, Middle, Last)					_ N	ate of Death	Day	Year	3. Time of De	
	Physicia /Medic	al	Phillip Carter	Pentz				Ja	n 16,	2005		10:15 F	М С
	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or		Death		4c. County			
			Southern Maryland			Clinto	n If Under 24	4 Hrs 0 D	ate of Birth	FILIC			o co ion
	Funeral Director		317 3L 3130	7. Age (In yrs. la	st birtnday) Yrs.	Months Days	Hours	Min. Au	Month, Day,	1940	Wash	lace (State or Fi try) nington	DC
	and *	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation					1	0d. Inside City L	Limits
	Maryl f sho	ō	Maryland Prince Geo	orge's C	Chelte	nham						1 ☐ Yes 2	₩ _{No}
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	<u></u>	10e. Street and Number 10316 Farrar Ave			10f. Zip Code 20623				g. Citizen of W United			
	death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of H	lispanic Origi an. Mexican.	in? (Specify Puerto Ricar	Yes or No-		e - Americ		
٥	or ite		1 Never Married 2 Married	1XXes 2□No 1957 If Yes, Give	7	1 Yes 2 No	Specify:		, - ,	Specify	,.		
200	nours LEAD.	d by	3 X Xvidowed 4 □ Divorced	Year or Dates: 1965	3	XX	-41			6b. Kind of Bu		nite	
2	natu	lete	15. Decedent's Educati (Specify only highest grade of	ompleted)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation <i>duri</i> ng most (d)	of working	'	ob. Kind of bu	2111022/1110	dustry	
2	within ane. than	Completed		College (1-4or 5+)		hanical H	_	er		Dept	of Na	avy	
N	filled y Hygie other i		17. Father's Name (First, Middle, Last)						st, Middle, M	aiden Sumam	ie)		
au	d be antal	To Be	Phillip Carter Pe	ntz				Rub	y Crai	lg Jone	:S		
	d 2 should be the and Mental I	F	19a. Informant's Name/Relationship (Type, Alan C. Pentz (Son		19b. Maili 4836	ng Address (Street 59 Sunburs	and Number st Dri	ve, Le	ute Number, exingto	city or Town, on Park	State, Zip , Ma	code) ryland 2	2065
e,	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.	-	20a. Method of Disposition		ace of Disp	osition (Name of matory or other place	on Jah	27 Date	205	Oc. Location -	City or To	own, State	
Baltimore,	ages ant of at: If it		14☑Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)			Veterans			,05	Chelten	ham,	Mary1a	nd
#	artme orten injur		21. Signature of Funeral Service Licensee	2,	2	2. Name and Addre	ss of Facility	Lee Fu	neral	Home,I	nc 6	633 Old	
Ba	Dep Imp gray		I det Della	10015	3	Alexandr	ia Fer	ry Roa	d, Cli	inton,	Mary	1and 20	735
~	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death cause on each line.	Do not en	ter the mode of dyir	ng, such as c	cardiac or res	spiratory arre	st,		Approximate Interval Betwe Onset and Dec	en ath
4	/Medical		resulting in death)	Due to (or as a consequ	ence of):	NAC FI DUODE	116	1				7 16 0	
n	Examiner	,	Sequentially list conditions, b.	SLEED !!	13	PUODE	NAL	DL	CER		- 4	1/445	
	D ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or):								
	and and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
760,	tificate be executed ig physician and as the burial-transit	cai E											
687	physis the		d										
× 6	ding	/Me	IF FEMALE: 23c	: If yes, outcome of pregna						23d. Dat	te of deliv	өгу	
О. Вох	The iaw requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	у			Мо	onth	Day Yea	ar
Δ.	res that the signed by be detact	/ Ph	Part II. Other significant conditions contri	ibuting to death but not resu	Ilting in the	underlying cause giv	ven in Part I.		23e. Did tob	acco use cont	inbute to t	he cause of dea	ath?
Sp.	uires sign	pieted by	CORONARY ARTE	ERY WISE	SE				1 ☐ Ye	s 2 No	3 Prot	oably 4 Duni	known
COL	w require been signal	iete	CATERSTIT IN	- LIVE	0,0	EASE			24a. Was ar	24b. \	Were auto	psy findings av	ailable
Re	The lavate has	Comp	AV 140 11/140		110	cvi =c			autopsy perform	ied?	death?	mpletion of cau 2□ No	Se OI
ā		S	25. Was case referred to medical				26. Place	of Death (CI	heck only on				
<u>=</u>		0 8	avaminar?	spital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA Ott	her: 4 Nur	rsing Home	5 🗆 Reside	nce 6 □Oth	ner (Speci	fy)	
of	g Phys er this eral di	n:T	27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time Injury		iry at	28d.	Describe ho	w injury occur	red		
ion	Attending r death. ector: After oy the fune	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 100.)	При		Yes 2 N	No					
Division of Vital Records,	at or Attend after death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, s	treet, factory, office		28f.	Location (Sti City or Town		er or Run	al Route Numbe	<i>∋r</i> ,
	Hospita 4 hours Funere ely fille	Medical C	29a. Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, dea tion and/or i	ath occurred at the ti nvestigation, in my	ime, date and opinion, deat	d place, and th occurred a	due to the ca	use(s) and ma ate and place,	anner as s	stated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A		29c. Licen	se number		25	9d. Date signe	d (Month,	Dey, Year)	
	- > = 0		I V A	M			12571	16		1/1	7/1)5	
2	•		30. Name and address of person who com	pleted cause of death (Item	23a) (Type	e, Print)	1			111	1 (1 ,	
1	5B1091		Kaufman, Low Mo.	7503 Surrat	ts Roa	d. Elinten, "	40.207	35. Sec	othern	Marylar.	id Hus	pital	
4	St	ate	31. Date filed (Month, Day, Year)	pleted cause of death (Item 7503 Surrat	turg.	Joanses					,		

					laryland / Dep			-	•	.
			1 - For State Registrar		Ce	rtificate o	f Death		Reg. Nd2 0 0	5 03196
	Physici	an	1. Decedent's Name (First, Middle, Las Richard St	teven Ph	ilmon			2. Date of Dea	ath Day Ye	3. Time of Death
	/Medio							Januar		
	Examir	ner	4a. Facility Name (If not institution, give				n, or Location of De		4c. County of D	
	-		Calvert Memoria 5. Social Security Number 6. So		L ge (In yrs. last birthday)		ce Frede		Cal	
	Funeral Director			M 2□F	63 Yrs.	Months Day		in. (Month, Da) Sep 26		Birthplace (State or Foreign Country) Orth Carolina
	P .		Usual Residence of Decedent					Dep 20	• TOTT TI	
	show	<u></u>	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ectc	MD Calve	ert	Port Re	-			40- 00	
	er death with the Marylan Items 23a or 28a-f show I er in tell te itelified	Funeral Director	3567 Hilltop Dr	ive		10f. Zip Code	9 0676		10g. Citizen of What	•
	death ms 23	era	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.			(Specify Yes or No- uerto Rican, etc.)		American Indian,
9	or Ite	E	1 Never Married 2 Married	Armed Forces 1 ⊠ Yes 2 ☐ If Yes, Give] No	If Yes, specify C 1 ☐ Yes 2 🔯 N		ierto Rican, etc.)		Vhite, etc.
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exercit with use be trofffed at	d by	3 Widowed 4 Divorced	Year or Dates					Specify:	White
15	thin 72 hours after e. an "natural", or It	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Oct kind of work do	cupation ne during most of ired)	working	16b. Kind of Busine	ass/Industry
21215-0036	ĭ C C S	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Locksm			Federal (Government
	be filed tal Hygid d other event, t	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)	
Var		To E	Ernest DeArmon	Philmon			Ruby			
Maryland	2 sho		19a. Informant's Name/Relationship (7						er, City or Town, Stat	
	1 an Heall em 2		Nannette Sturgess 20a. Method of Disposition	s (compan	20b. Place of Disponsional Company Com			Port Repu	20c. Location - City	20676 or Town, State
Baltimore,	of of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	Maryland			Feb 1 2005		
Ħ	그 문 뿐 글		21. Signature of Funeral Service Licen				1		_Cheltenk al Home Ca	alvert, PA
m	Departiment of the particular in the particular		Gary J. Got	f f	100			ryland Bly		gs, MD 20736
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the death. Do not en line.	ter the mode of o	tying, such as care	diac or respiratory ar	rest,	Approximate Interval Between
	Pnysician.		Immediate Cause (Final disease or condition	0 1	monary	embo	1			Onset and Death
	/Medical Examiner		resulting in death)		s a consequence of):	7.				- J
		<u>i</u>	Sequentially list conditions.	b. Due to (or a	s a consequence of the	rombos	is y ri	ght subcl	mien vein	days
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Consi	utive he	N+ Fee	lune			nunths
ó	be executed sician and burial-transit		resulting in death) Last	a `	s a consequence of):		1.5			
8760	# × #	licai		d () (onary a	rtery	disea	عو		years
x 68	The law requires that the death certificat ite has been signed by the attending phyage 2 should be detached for use as th	/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy					
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	∃Ectopic pregna ∃ Other (specify)			23d. Date of Month	Day Year
O.	that the de ned by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown					- Addition	
ď.	res that igned b	by PI	Part II. Other significant conditions of	0.4			given in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ord	w require been sig should b	ted	Stage 3 squar	mon, cell	Carcihoma	a of e	piglotti.	<u>∤</u> 1□Y	′es 2□No 3⊊	Probably 4 Unknown
Vital Records,	e lawr has be je 2 sh	Completed	Diabetes melli	tuz, typ	e I	<u>'</u>		24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
<u>=</u>		Sol	Acaleulous ch	ole us tit	13			perfor 1 ☐ Yes	rmed? death	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Death (Check only or		
of	Phys r this ral di	2	1 Yes 2 No	28a. Date of Ini	urv 28b. Time o	IL 3 DOA	4 Nursin		lence 6 Other (S	(pecify)
ion	Attending Phy ir death. ector: After thi by the tuneral o	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Injury	V	∛ork? □ Yes 2 □ No			
Division	r Attendi er death. rector: A by the tu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace of II	njury - At home, farm, str atc. (Specify)	reet, factory, offic	20	28f. Location (S City or Tow	Street and Number or	Rural Route Number,
	ital o irs aft ral Di							1		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	edical	29a. Certifier 1 Cartifying Ph. (Check only one) 2 Medical Exam	ysician: To the bes ninar: On the basis and manners	t of my knowledge, deat of examination and/or in	h occurred at the vestigation, in m	time, date and play y opinion, death o	ace, and due to the concurred at the time, o	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and marinor s	iated.	29c. Lice	nse number	2	29d. Date signed (Me	onth, Day, Year)
	F > F 0		> Q1/1 . ms	D HOSPI	TALIST	06	0390		01/20/	2005
	. .		30. Name and address of person who d	completed cause of				C .	/	- 1 - 0
/	5+1		ADEER JABER	, 100	death (Item 23a) (Type,	120.	Prince	trederick	, mp 2	.5678
	· Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	Reserved J.	Aco. De				
	riegisti	С.	JAN ~		MIRENAL IN	P. P. P. P. C.				

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:56 12M riesex+ Jasmine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1 M 210 F Yrs. Feb. 4, 1993 11 Washington, Director 579-23-2582 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at XXYes 2 No Directo Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 20715 , or Itema 23a United States 12605 Knowledge Lane Completed by Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Madical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental hy Important: If tiem 27 is marked oth any injury or other traumatic event once. Be Michael Hester N/A 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Father 12605 Knowledge Lane, Bowie, MD 20715 MIchael Hester 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/20/05 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Ligenses berry 7400 Georgia Ave. N.W., Washington, D.C. 20012 sanna 23a. Part. Enter the disease, of complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final l resordation Silve h YVE Physician und core disease or condition resulting in death) /Medical Examiner acedeur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Late has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending efter death. Director: Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e e Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MS 2689 1-10-05

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNERT

32 Registrar's Signature

WOLFGANG

19

2005

31. Date filed (Month, Day, Year)

3800 RESERVOIR

WASHINGTON,

		-	For State Registrar	State of M	larylan				ealth a	and M	•	giene Reg. No.	005	0319	8
	Physicia	212	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	ath Day	Year	3. Time of De	ath
	/Medic	al	Hayward	Frank		Pic	kens	_		(David	Januar			6:40p	m
	Examin	er	4a. Facility Name (If not institution)				Location of	or Death			County of Deatl	n	
	Francis		6510 Haviland 5. Social Security Number		ge (In yrs.	last birthday)	If Unde		If Under		8. Date of Birt	h	ward 9. Birtl	hplace (State or Fo	oreign
	Funeral Director		235 16 2051	1 ½ M 2□ F	89	Yrs.	Months	Days	Hours	Min.	(Month, Da		1	^{uintry)} est Virg	inia
	pu ,		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	ocation							10d. Inside City L	
	ehov	5	Maryland Howa	rd		arksvi								1 ☐ Yes 2	
	28a-1	Director	10e. Street and Number			arkov i		Code				10g. Citiz	en of What Co	untry?	
	h with	ID I	6510 Haviland M	ill Road				21	.029				USA		
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	.S. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)	- 1-	4. Race - Ame Black, White	rican Indian,	
36	or its	y Fu	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2	No		1 🗆 Yes		Specify:				2	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Itama 23e or 28e-f ehow ant, the Medical Examiner must be notified at	Completed by Funeral	15. Decedent	Year or Dates:	-	16a. Dece	dent's Usu	al Occupa	ation			16b. Kin	d of Business/		
5	in 72 n na	plet	(Specify only highes	t grade completed) College (1-4or	. 5.1)	(Give	kind of w	ork done d ise retired	during mos	t of workii	ng			,	
212	d with giene or tha	E O	Elementary/Secondary (0-12)	College (1-40)	3+)	S	elf 1	Emplo	yed			Co	nstruc	tion Com	pany
	al Hy d othe	Be	17. Father's Name (First, Middle,	Last)				1	18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)		
yla	ould to	၉	Lafayette Lee			401 14 18		/0			ell No			F- C- 4-1	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f ehow any injury or other traumatic event, the Medical Exeminer must be multipled any once.		19a. Informant's Name/Relations Ethel M. Picke	•									Town, State, Z	1and 210	20
ē,	1 and Healt tam 2		20a. Method of Disposition	ns / wile	20b. F	Place of Dispo	osition (Na	me of			ate		ation - City or		23
<u>0</u>	ages ont of		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			emetery, cre Linc o				1/21	/2005	Brent	wood,	Maryland	
Baltimore,	mit. F partme portar / injur		21. Signature of Funeral Ferric			2	2. Name <i>a</i>	nd Addres	ss of Facilit	Hine	s Rina	ldi F	uneral	Ноте	
ä	Per in the second		- Court	elmor										g, MD 209	904
,1260,	/Medical Examiner whise parial-transit	cal Examiner	Immediate Gause (Final disease or condition resulting in death) Sequentially list conditions, and the same of the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chron Due to (or a	ic Hy s a conseq ary A	perten	sion							_20_Years	5
.O. Box 68	death certific e attending p id for use as f	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	il déath 3[⊒Ectopic ; ⊒ Other (s					2:	3d. Date of del Month	ivery Day Yea	ır
ds, P	P P P P P P P P P P P P P P P P P P P	by	Part II. Other significant condition	ons contributing to death	but not res	sulting in the t	underlying	cause give	en in Part I			obacco us Yes 2 🛚	_	the cause of deat	
Record	> 11 0	Completed	Ta Ta								24a. Was		24b. Were au	topsy findings ava	iilable
Re	e 4 e	mo									autor perfo	osy ormod? 2 No	death?	completion of caus 2□ No	e or
Vital		a	25. Was case referred to medica						26. Place	of Deatr	(Check only				
of V	S S D	To B	examiner? 1 ☐ Yes 2 ★ No	Hospital: 1 🗌 Inpa		ER/Outpatie			4 INI				Other (Spec	cify)	
		on:	27. Manner of Death XXNatural 5 Pendir		jury Jay Year)	28b. Time of Injury		28c. Injun Wor			28d. Describe	how injury	occurred		
isic	eat or:	cat	2 Accident investi	not be an Place of I	niury - At h	ome farm st	M reet facto		Yes 2 🗌		28f. Location (Street and	Number or Ru	ıral Route Number	r.
Division	그 분 분 교	Certification:	4 Homicide determ	building,	etc. (Speci	fy)	., , , , , , , , , , , , , , , , , , ,	,,,			City or To	wn, State)			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C		ng Physician: To the bes Examiner: On the basis and manner	of examina										
	To the within 2 To the comple	Me	29b. Signature and title of certifie	1.11.			2	c. Licens		-			signed (Mont		
			> /W/X	ulu)				D330	62			Jan	uary 19	9, 2005	
	30		30. Name and address of poson	11	1810	9 Prin	ce Pi	ni11i	p Dri	ive #	225 01	nev.M	[arvlan	d 20832	
	Sta Regist	ate rar	Robert A. Gal 31. Date filed (Month, Day, Year)	2005 32. egis	strar's Sign	ature A	parti	,				, , , , ,			

			For State Registrar	State of Ma	ryland / Depa		ealth and Me	ental Hygie	ene				
			Registrar 1. Decedent's Name (First, Middle, Las	el .	Ce.	runcate or t		Reg 2. Date of Death	I. No	3. Time of Death			
	Physici	an	Joseph Horace Quade,	· _				Month	Day Yea				
	/Medic	- 2	4a. Facility Name (If not institution, give			4h City Town or	Location of Death	JANUARY	21 200 4c. County of D				
	Examin	ier	St. Mary's Hospital			Leonard			St. Mai				
	Formary 1		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,)		Birthplace (State or Foreign Country)			
	Funeral Director			™ M 2□F	62 Yrs.	Months Days	Hours Min.	(Month, Day,) Sep.18,194	√ear) •2 Maı	cyland			
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
	Mary -1 eh	to	Maryland St. Mary'	s	Mechanicsv	ille				1 ☐ Yes 2X No			
	r 28e	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What	Country?			
	23a o		20717 Laurel Grove R	oad		20659			USA				
	deat ms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No-	14. Race - A Black, W	merican Indian,			
36	72 hours after death with the Maryland naturel', or Items 23a or 28e-f ehow Jisal Evaninar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 N Yes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2X No	Specify:	1001, 00.7	Specify: V				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. Item 27 is marked other then "naturel", or teems 23s or 28e-1 ehow tiem 27 is marked other then "naturel", or teems 23s or 28e-1 ehow other treumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	(Give	dent's Usual Occupa	during most of workin	g 16	6b. Kind of Busine	ss/Industry			
121	within ene. then	du	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired k Driver	"	1	ransportat	·ion			
d 2	S should be filed withir and Mental Hygiene. Is marked other then eumatic event, tra Mi		11. 17. Father's Name (First, Middle, Last)		1230		18. Mother's Name						
an	d be ental ked o	To Be	Joseph Horace Quade,	Sr.			Margar	et Flora					
Maryland	should and Men	۳	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a	and Number or Rural		City or Town, State	s, Zip Cods)			
	and 2 ealth a n 27 is		Angela D. Quade/Wife		20717	Laurel Grov	ve Road, Mec	hanicsvill	e. MD 2065	9			
ē	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispe		Da		c. Location · City				
Ë	0		1 ☐ Burial 2 🙀 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State /)				2005 41	evandria	Vircinia			
Baltimore,	元年五年		21. Signarde of Funeral Service, Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home,										
Ö	Depo Impo any once		Mechael Neven	Harden &		P. O. Box 27	70, Leonardt	own, MD 2	0650	,			
	Physician /Medical		23a. Part1. Enter the disease, or or fin shock, or heart failur! List only Immediate Cause (Final disease or condition resulting in death)	a	θ.					Approximate Interval Between Onset and Death			
1760,	te be executed by sixty in the burial-transit representation and the burial-transit representation in the burial-transit r	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	b. Chron Due to (or as a	consequence of):	nctive	fulmona	ry D	Nask	one day Ten years			
P.O. Box 68	iicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the bural-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year			
	ss that I gned by se deta	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	underlying cause give	en in Part I.			e to the cause of death?			
ord	equire sen si	ted		· · · · · · · · · · · · · · · · · · ·				1 XYes	2 □ No 3 □	Probably 4 Unknown			
Reco	The law r te has be age 2 sh	Completed	<u> </u>					24a. Was an autopsy performe	prior				
ta	en: tifica tor, p	Be C	25. Was case referred to medical				26. Place of Death			7			
Ž	Physicien: r this certificanal director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 3 DOA	er: 4 🗆 Nursing Hom	ne 5 🗆 Residen	ce 6 Other (S	pecify)			
o uc	ding Phys h. After this funeral di	ion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injun (Month, Day)	Year) 28b. Time of Injury	Worl	yat 2 k? Yes 2 □ No	8d. Describe how	injury occurred				
Division of Vital Records,	deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, st . (Specify)			8f. Location (Stre City or Town,		Rural Route Number,			
	To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	Medical (29a. Certifier (Check only one) Certifying Ph	ysicien: To the best on niner: On the basis of and manner sta	examination and/or in	th occurred at the time envestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	se(s) and manner e and place, and c	as stated. due to the cause(s)			
	omple	Me	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Mo	onth. Day, Year)			
	~ > ~ O		> SC Gabo	M.	D ·	DS	54346		1/22/	05			
1.	100		30. Name and address of person who CHANDRA SAJJA	completed cause of de			20636		. /				
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 6	32 Raffistra	r's Signature	South							
	negist	rel	5711120	A SECTION	12 1 1 A								

DHMH 17 Rev 1/2001

JOSEPH HORACE QUADE JR

			1 - For State Registrar	State of Maryland / Depa	artment of Health and I	, ,	ene 2005	03200
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Allen Delmo	ont Rager		January	Day Year 21, 2005	5:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	3.13.12
	Zxamii	•	21696 Kearsarge I	lace	Lexington Park		St. Mary	s
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthpl	lace (State or Foreign try)
	Director		214-38-2158	62 Yrs.		Aug. 6,		ylvania
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	Od. Inside City Limits
	f sho	ō	ND Ch Man	la Lovino	ton Park			1 ☐ Yes 2 📉 No
	the t	rect	MD St. Mar	y's Lexing	ton Park	10	g. Citizen of What Coun	try?
	3a or	Funeral Director	21696 Kearsarge	D1 222	20653		United Sta	tes
	ms 2	era			Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - America	an Indian,
9	or Ite	Fur	1 Never Married 2 Married	1 ☐ Yes 2 📉 No		o Hican, etc.)	Black, White, e	
93	ral', c	d by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show fra Madical Exatta for fruit by matified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wor	king 1	6b. Kind of Business/Ind	lustry
121	han he.	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		0	-1
2	filed with Hygiene. other than		9th 17. Father's Name (First, Middle, Last)	- Tro	uck Driver	ne (First, Middle, M	Constructi	.on
anc	ould be fi Mental H warked ot tatic ever	Be	Irvin Miles Rage	2		Grace Irv		
ž	2 should be filed and Mental Hygi is marked other aumatic event,	မ	19a. Informant's Name/Relationship (Type		ng Address (Street and Number or Ru			Codel
Maryland	d 2 sl th an 7 is r traur			utza (Daughter) 21			•	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, ite Macdical Exert for court		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Oc. Location - City or To	
Baltimore,			1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from Staye			Charalanta II	-11 MD
Ė	+ E E E		21. Signature of Funeral Service Licenta		ld-Echols Cremator 2. Name and Address of Facility Ro		Charlotte H Funeral Ho	
Ba	permi Depa Impo any it		David A. Goff	nrai	2955 Hollywood Rd			
			23a. Part1. Enter the disease, or complic	erions that caused the death. Do not ent	ter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Frrysician		Immediate Cause (Final	METASTATIC	NON SMALL C			Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):				314 63 1412
6	Examiner		Sequentially list conditions b					
		ner	if any leading to immediate	Due to (or as a consequence of):			3	
	cutec nd rransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
0,	sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):				
68760,	± ≥ 5	dical	d					
9	death certifica attending ph d for use as th	Physiclan/Med	IF FEMALE:	A. 16				
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Year
0	the s	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death 5 ☐ 9 Unknown				*
0	The law requires that the de ate has been signed by the a bage 2 should be detached f	, Ph	Part II. Dther significant conditions con	tributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
Records,	uires sign	d by				I ₽ Yes	2 □ No 3 □ Proba	ably 4 Unknown
20	w requir been si should	Completed				24a. Was an	24b. Were autor	osy findings available
Re	The lay	E C				autopsy perform	ed? prior to con death?	npletion of cause of
Vital		e C	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2		2 NO
>	Phyaician: this certific ral director,	0 8	avaminar?	ospital:	Others		ce 6 □Other (Specify	•)
l of		H: U	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time o	-	28d. Describe how		
Division	vttendin death, ctor: Aft y the fun	atio	Natural 5 Pending 2 Accident investigation	(Manual, Day Four) Injury	M 1 ☐ Yes 2 ☐ No			
V _i S	er der recto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	talor rs aft al Dii	Certification;						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune		(Check only 2 Medical Examir	ician: To the best of my knowledge, deat ler: On the basis of examination and/or in				
	thin 2 the the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29	d. Date signed (Month, L	Day, Year)
	F 3 F 8		A CAN AN		D 50696			
	0:40		20 Name and address of account	mploted cause of death (It co-) (T			January 24,	2005
	2		· ·	mpleted cause of death (Item 23a) (Type, bra, M.D. 25500 Poi		onard+or	n MD 20650	
	Sta	ite	31. Date filed (Month, Day, Year)	Dra, M.D. 25500 Pol	LIIC LOOKOUL KU. LO	-OIIALU LOW	<u> 2000 ست</u> و ۱۱	
	Regist		JAN 2 3	CUUD Marie 1				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Tima of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dalin 4:4000 **Physician** Rakowski January 16,2005 Rober + /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 40 r If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Security Number 6 Say **Funeral** Months Davs Hours 152M 2□F Yrs. 27, 1950 |Illinois Director 220.46.5695 54 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State worle r 28e-f ehow 1 ☐ Yes 2 No Director Maryland Ellicott City Howard 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Item 27 is marked other then "naturel", or items 23s or other treumatic event, the Medical Examinating must be 21043 5432 Simpkins Court U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Iter Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Supervisor U.S. Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward J. Rakowski Stephanie J. Badach ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5432 Simpkins Court, Ellicott City, Maryland 21043 Maureen M. Rakowski / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
eny injury or ot
200.9 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemet. 01/22/2005 Silver Spring, Maryland 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses Namce 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Intracranial Hemorrhages 2 days Multiple /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the b IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier > 60 January 16,2005 => MO RES-000 σ_J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peters Johns Hopkins Hospital 600 North Wolfe Street Beltimore, Maryland Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 9 2005 JAN

		1 - For State Registrar	State of Marylar			nt of Health a te of Death	and Me		iene	2005	0320
Physicia		Decedent's Name (First, Middle, Last) December Mi	dred Reynolds	3				Date of Death Month January	Day	Year 2005	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give: Heritage Harbour F	street and number)	.		, Town, or Location o		, assume y	4c. 0	County of Death	
Funeral Director		5. Social Security Number 6. Sex		last birthday, Yrs.		er 1 Year If Under 2	Min.	Date of Birth (Month, Day, -6-191	Year)	9. Birth	place (State or Forei ntry) aware
death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	10a. State 10b. County Maryland Queen Anr		ty, Town or L	eştei						10d. Inside City Limi 1 ☐ Yes 2 🛣
3a or 2	I Dire	10e. Street and Number 112 Dundee Avenue				ip Code 619		10	0g. Citiz	en of What Coul	ntry?
	by Funeral		12. Was Decedent Ever in U Armed Forces? 1	l.S. 13.	Was Dec	edent of Hispanic Origeoffy Cuban, Mexican 2 No Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)		4. Race - Americ Black, White,	
within 72 hours after ene. than "netural", or Ite	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	e kind of v DO NOT	ual Occupation rork done during most use retired)	of working			d of Business/In	,
Table .	To Be Cor	2 17. Father's Name (First, Middle, Last) William Andrew	years Cosden	l Or	wner	Operator 18. Mothe		First, Middle, M Sie Ann	faiden S		enter
od 2 s lith ar 27 is r trau	_	19a. Informant's Name/Relationship (Ty	•			ss (Street and Numbe					
Pages 1 ar nent of Hea int: If item iry or otha		20a. Method of Disposition 1	emoval from State	Place of Disponentery, cre	osition (N matory of	ame of other place)	Date -17-05	9 2	20c. Loc	eation - City or To	own, State
permit. Pages 1 Department of H Important: If ite any injury or ott 2005.		21. Signature of Funeral Service License		2	2. Name	and Address of Facility	y Geor	rge P.	Kala	as Funer	cal Home
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer of each line. Due to (or as a consect	Estru	eter the mi	11 1	cardiac or re	11		_	Approximate Interval Between Onset and Death
ate be executed hysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) Du								
sicien: The law requires that the death certifica certificate has been signed by the attending phrector, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	aldeath 3	□Ectopic □ Other (pregnancy specify)			23	3d. Date of delive	ery Day Year
equires tha en signed ould be det	þ	Part II Other significant conditions con		sulting in the u	underlying	cause given in Part I.			acco us		he cause of death? pably 4 AU know
n: The law ricate has be	Completed		thrive					24a. Was ar autopsy perform 1 Yes 2	ned? ZNo		opsy findings availab impletion of cause of 2 No
Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 Yes	lospital: 1 Inpatient 2	ER/Outpatie	nt 3□ [Othor		Check only one 5 □ Reside		□Other (Specif	(v)
itending Physicien: The I beath. tor: Atter this certificate ha the funeral director, page	atlon: T	27. Manner of Death 1 \(\sum_{\text{Accident}} \) 2 \(\text{Accident} \) 2 \(\text{Accident} \)	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe								,,
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, facto	ory, office	28f	Location (Str City or Town	eet and , State)	Number or Rura	al Route Number,
To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledical	29a. Certifier 1 Check only 2 Medical Exami	sicien: To the best of my known of the basis of examination and manner stated.	owledge, dea ation and/or in	th occurre	d at the time, date and on, in my opinion, deat	d place, and th occurred	due to the ca at the time, da	use(s) a ite and p	and manner as s place, and due to	tated. the cause(s)
To t With: To t	×	29b. Signature and title of contiller				9c. License number	8			signed (Month,	_
Sta	ate	30. Name and address of person who con Aditya Chopra, 31. Date filed (Month, Day, Year)	M.D. 600 Rido	relv Av	, Print)	Annapolis,		1401			

			_ For	rieasc	State of							lental Hygi		O O F	
			1 - Stata Registrar				Cei	tificate	e of E	Death			g. No.	005	03203
	Physici	an	1. Decedent's Name (st)			D 1				2. Date of Death _Month	D	2005	3. Time of Death
	/Medic	cal		izabeth				Reed		Location o	(Dooth	January	, 	2005 ounty of Death	8:55pm [™]
	Examin	ier	4a. Facility Name (If n			er)				leric				Freder	
	Funeral		5. Social Security Nun			Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth	<u> </u>	0. 0:46	pplace (State or Foreign intry)
	Director		083-05-944	9	1 □ M 2 💢 F		91 Yrs.	Months	Days	Hours	Min.	June 23,	191	13 Con	New York
	pu s		Usual Residence of D	ecedent 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	Aaryla f sho	ō	Maryland	Frederi	i o k		ederio								1 ☐ Yes 2 🙀 No
	the 1	Funeral Director	10e. Street and Numb		LOK		edelic	10f. Zip	Code			10	g. Citize	n of What Cou	untry?
	h with	ai D	6390 Overb	rook Ci	rcle				2170	2			U	.S.A.	
	ams ams	iner	11. Marital Status		12. Was Deced	es?	.S. 13.	Vas Decede	ent of His	spanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)	14	. Race - Amer Black, White	
36	or It	by Fu	1 ☐ Never Married 3 👿 Widowed 4	_	1 Tes 2	™ No		I□Yes 2		Specify:		, , , , , ,	S		hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show he Madical Examinar must be notified at	ed b		5. Decedent's E	Year or Date	es:	16a. Deced	lent's Usual	l Occupa	tion			6b. Kind	of Business/li	
215	nin 72 in "na Medis	piet	(Specify	only highest gr	ade completed) College (1-4	or 5+)	(Give life.	kind of wor DO NOT us	k done di e retired)	uring most	of work	ing			
212	d with giene gritha	Completed	Elementary/Second	12				Secre	etary	r			Pub1	ic Sch	ool System
pu	iould be fitad v I Mental Hygie narkad othar t netic evant, tt	Be	17. Father's Name (Fi		")							e (First, Middle, N			
<u>¥</u>	should ind Men ind Men ind marka	Ç	Louis Jac		T D-'1		405 14-75					Anna Pe			
Maryland	d 2 sho		Nancy E.					•	•			al Route Number,	,		nd, 21702
	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show may injury or other treatmetic event, the Madical Expander must be notified at any injury or other treatmetic event, the Madical Expander must be notified at angle.		20a. Method of Dispos		igiter	20b. F	Place of Dispo							tion - City or T	
MO	Pages nent of h int: If its iry or of		1 ☐ Burial 2 🔀 1 ☐ Donation 5	Cremation 3 ☐	Removal from St	ate	thsbur				1/30	/2005	Smit	hehura	, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fune			44.46		. Name and				72000	Omre		t Church St.
ä	Department Department		D.	Figur	MªMu	llian	Ke	eeney a	md Ba	sford	P.A.	Funeral H	ome	Frederi	.ck, MD, 21701
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that cau one cause on eac	ised the deat th line.	h. Do not ent	er the mode	of dying	, such as	cardiac (or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fi disease or condition resulting in death)	nal	a Intra	crania	l blee	ding							Oriset and Death
	/Medical Examiner		resulting in death)	(
		e	Securifically list rand if any, leading to imm	Mians		teral	subdur	ar ne	mato	ma			W	1010	<u>d</u>
11	uted d ansit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	ring jury	Head	trauma	due t	o fal	1 at	home	2	~ 1	1	Approve	
0,	te be executed ysician and se burial-transit		resulting in death) La	st	Due to (or	as a conseq	uence of);				ما	Mitiga	(3)	D. ex	
8760,	9 % 9	licai			d					AT	+P	Zaricica Zaricdica 139. Did tob	2	amilio	
x 68	entific ding p	/Med	IF FEMALE:		23c. If yes, outco	ome of pregns	incv			111	1	Colick Co	1		
Вох	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	23b. Was decedent p in the past 12 m	onths?	1 Live birt	h 2 Feta	Ideath 3	Ectopic pre	egnancy	Jed's	CON.	Larmedie	230	d. Date of delive Month	Pery Day Year
O.	that the dened by the a	ysic	1 ☐ Yes 2X1 9 ☐ Unknown	No	9 Unknow		54	JOMBI (Spe		ATIC	TE DI	(C)			
٦.	s that ned b		Part II. Other significa	ant conditions	contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
rds	w requires been signe should be	ed b	C.O.P.D.	; DVT;	Hodgkin	s Dise	ase						2 K	No 3□Pro	bably 4 Unknown
Records,	e law requ has been ge 2 shoult	Completed by	Dementia	ì								24a. Was ar		24b. Were aut	opsy findings available ompletion of cause of
<u> </u>		Соп										perform 1 ☐ Yes 2	ed?	death?	2□ No
Vital	ding Physician: The h. Atter this certificate funeral director, pag	Be	25. Was case referred examiner?		Hospital:							h (Check only one			
of	Phys this ral di	.To	1 Yes 2 No. 27. Manner of Death	0	28a. Date of		ER/Outpatien 28b. Time of		Bc. Injury			me 5 🔀 Resider 28d. Describe ho			fy)
on	ding th. After	tion	1 ☐ Natural 2 ☑ Accident	5 Pending investigation	(Month,	<i>Day Year)</i> 200	Injury		Work'	? ′es 2.⊊l		Fell wh			2
Division	Atten r deal actor	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	OB Diago					Λ	_	28f. Location (Str	eet and f	Number or Rui	ral Route Number,
Ö	tal or	Certification:	4 [] Homicide		At h		y)					City or Town.		6390 O Marvlai	verbrook Cr
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Pi	hysician: To the b miner: On the bas and manne	est of my kno is of examina r stated.	wiedge, deati	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, th occurr	and due to the ca red at the time, da	use(s) ar te and pi		
	To the To the comple	Me	29b. Signature and tit	tle of certifier	1/1	1		29c.	License	number		29	d. Date s	signed (Month,	Day, Year)
			> 81h	cell!		U			141	132	8		1/	29/01	
	VO.		30. Name and address	s of person who	completed cause	of death (Iten	n 23a) (Type,	Print)			4.		de la	2011	0
	10		31. Date filed (Month,	Day Year	VITOW POW	gistrar's Signa	ILL.	FN:0	1/2/	lh,	MO	/	1/1/	MILL W	Cojasib
	Sta Registi		FEB 0		32. 110	, Juliar a Gigita	Speak	· p							17.0.
					- The Contract	Manufaction of the Party of the	ALT THE PARTY OF								

		_	For State Registrar	State of M	Marylan		artment of h				Reg. No. 2	2005	03201	
	Physici /Medic	an	Decedent's Name (First, Middle)	Eileen M	lay Robe	ertson				2. Date of De Month	ath Day	Year O5	3. Time of Death	
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, o	or Location o	f Death			ounty of Deat		
					PTTAL			BERL				LEGI		
ı	Funeral Director		212-24-1901	6. Sex 7. A 1 M 2 🕱 F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under a	Min.	8. Date of Bir (Month, Da Decembe	th y, Year) er 30, 192		thplace (State or Foreign buntry) Maryland	
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits	
	ne Maryl Be-f sho	ector		Allegany			1.04 50 0	Lonaco	ning		10.000	(14)	1 □ Yes 2 ☑No	
	th with the 23a or 2	al Dire	10e. Street and Number	9 Gills Hill			10f. Zip Code	2153	9		10g. Citizei	n of What Co U	SA	
036	72 hours after death with the Maryland neturel', or Herns 23a or 28e-f show Jost Examinational be motified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Tyes 2 3 If Yes, Give Year or Dates	s? ₹No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Originan, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		Race - Ame Black, Whit pecify:		
Maryland 21215-0036	within 72 ho ene. than "netur ne Madical	mpleted	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		ır 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most		ng	16b. Kind	of Business	Industry ome	
and 5	d be filed vental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, I		erger			18. Mothe	r's Name	(First, Middle, Elle	<i>Maiden S</i> u en May			
Mary	and 2 should salth and Men n 27 Is marke ler traumatic	19a. Informant's Name/Relationship (Type, Print) George Robertson/ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or 9 Gills Hill, Lonaconing, Marylan 20a. Method of Disposition 20b. Place of Disposition (Name of Date Computer computer computer computer computer computers co												
Baltimore,	t. Pages 1 tment of He rtant: If iter ijury or oth		20a. Method of Disposition 1 **Description** 2 **Description** 3 **Description** 5 **Description** Other (Sp. 12)	osition (Name of matory or other pla el Hill Cemete			ate bruary 01, 2005		tion - City or oscow Mi	Town, State lls, Maryland				
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service t	icensee			2. Name and Addre Eichhorn-McK		•	Iome 8 Eas	st Main S	t., Lonac	oning, Md. 21539	
	Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence 1):											
8760,	cate be executed chysician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Op YO	as a consequal as a consequ	uerice of).	~bery	D	i se	ase			241045	
.O. Box 6	death certifii e attending p od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	Ideath 3[⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	ey			230	d. Date of de Month	livery Day Year	
rds, P	ngi be	by	Part II. Other significant conditions of Normal Conditions and the conditions of the		but not resi	de	inderlying cause gi	ven in Part I.			obacco use 1es 2□1		o the cause of death?	
of Vital Record	The law ate has b page 2 sl	Completed								24a. Was autoj perfo		prior to death?	utopsy findings available completion of cause of 2 No	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Ot	hor		(Check only o						
	ing Phys After this uneral dii	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin			28b. Time of Injury	of 28c. Inju	ry at	2	ne 5 Resi			cify)	
Division	or Attentifier deal	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28d. Date of Injury M 1 Yes 2 No 28d. Time of Injury Nort? 28d. Date of Injury Nort? 28d. Date of Injury Nort? 28d. Time of Injury Nort? 28d. Time of Injury Nort? 28d. Date of Injury Nort Injury								28f. Location (City or To		Vumber or Ri	ural Route Number,	
	Hospite 24 hours Funerel tely filler	edical C		g Physicien: To the be Examiner: On the basis and manner	of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	01			29c. Licen	se number			_		h, Day, Year)	
,	\		30. Name and address of person	who completed cause of	death (Item	1 23a) (Tvna	Print)	200			1-	39-0	05	
	4		DR. ARUMUAL	nam Pill	ai	915		Drive	2 0	umbe	RIAn	d.m.	D 21502	
	Sta Regist		31. Date filed (Month, Day, Year)		strar's Signa						,			

			1 - For State Registrar	• •	Department of Health and M Certificate of Death	•	005 03205
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, La L-Ster Roge 4a. Facility Name (If not institution, giv Nashington Adv. 5. Social Security Number 6.5	e street and number) And it Horytal	4b. City, Town, or Location of Death Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color Color	0 pri	
	Funeral Director			1	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 01-20-195	
	e Marylan ta-f show tifled at	ctor	MD PG	10c. City, Tow	m or Location Hyattsville		10d. Inside City Limits ty⊡ Yes 2 ☐ No
	ath with th	rai Dire	10e. Street and Number 6700 Belcrest	Rd. #1022	10f. Zip Code 2 0 7 8 3		zen of What Country? USA
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any figury or other treumatic event, ite Madical Exemplar must be notified at once.	d by Funeral Director	11. Marital Status ★□ Never Married 2□ Married 3□ Widowed 4□ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 Hoo Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	ad within 72 h rgiene. er than "netu i, it e Medica	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Unemployed	ing	nd of Business/Industry
Maryland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last Joseph E.	Davis —	Ernest		rs
	t and 2 shot leath and 27 is mether treum		Ava Dyson/ Dau 20a. Method of Disposition	ghter 22	b. Mailing Address (Street and Number or Run 3 Harry S. Truman of Disposition (Name of	Dr. #24	
Baltimore,	t. Pages rtment of h rtent: if it		1⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special	Removal from State Mt. O	ary, crematory or other place)	1-05 Was	hington DC
Bal	Depa Impo any ir		21. Signature of Funeral Service Lice	Church II	1722 North Capit	_ 1/r	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury	a. Due to (or as a consequence		or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	tificate be executed g physician and as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	of):		
.O. Box 68	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 Ectopic pregnancy 5 Other (specify)	2	23d. Date of delivery Month Day Year
rds, P.	w requires that been signed I should be det		Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco u 1 Tes 2	se contribute to the cause of death?
al Records,	The ate h page	Completed				24a. Was an autopsy performed? 1 ☐ Yes ② No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes □ No
Vital	Physicien: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 12 Inpatient 2 □ ER/O		n <i>(Check only one)</i> me 5 ☐ Residence 6	S ∏Other (Specify)
Division of	the the	ation; T	27. Manner of Death 12 Natural 2 Accident 2 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.		28d. Describe how injury	
Divi	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)		City or Town, State	
	s Hosp 24 hou ie Fune letely fi	edical	29a. Certifier T. Certifying Pl (Check only 2 Medical Exer	hysician: To the best of my knowledg miner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)
	To the company of the	W	29b. Signature and title of certifier		29c. License number DOD6/962		e signed (Month, Day, Year)
	JC		30. Name and address of person who	completed cause of death (Item 23a)		hAN Ira	SHN
	Sta Regista		31. Date filed (Month, Day, Year) JAN 1 9 2005	32. Registrar's Signature	U		

		Please	Type or Prin					•		egible.	
		For	State of Ma	aryland .	•	artment of F		nental Hyg	gienę,	000	00000
		1 - State Registrar			Ce	rtificate of	Death	P	leg. No:-	000	03206
		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	Year	3. Time of Death
Physic /Medi		Mary Maxine	Swaug	لعر				January	_ Z3	2005	5 1439 M
Exami		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death		4c. Co	ounty of Deat	h
		Washington Covi	Aty HOSE	ital		Hazer	stour		1Da	where	iton
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last	birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1	9. Bifti	hplace (State or Foreign
Director		216-22-5712	□ M 2 20X	79	Yrs.	William Buyo	110013		3,192		ryland
pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	'au-a a d l						
anyla shov	-			Toc. City, 1							10d. Inside City Limits 1 Yes 2 No
8a-f	Scto		ngton			Hagersto	wn				
If Z 12.13-0030 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Exercit at coalined at	by Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	ountry?
ath v	ral	1113 Oxford Cir	Т.				21740			USA	
er de Reme	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White	
s aft	γF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🕱 No	Specify:		S	pecify:	white
tural hour		15. Decedent's E		1	6a Doce	ident's Usual Occup	astion		16h Kind	of Business/i	
n 72	let	(Specify only highest gra	ade completed)		(Give	kind of work done DO NOT use retire	during most of work d)	ring	160. Killa	O DUSINGSS/I	industry
within than the	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ocker	-,		rib	bon c	ompany
Hyginther and		17. Father's Name (First, Middle, Last	<u>-</u>				18. Mother's Nam	Θ (First, Middle,	-		o.i.j.d.i.y
d be and a company	Be	Sloan David Ho					Agnes	Lillian	Twic	10	
ite, INIGITYIGITIU ZIZIOOOO s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Ifteath and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, if a Medical Exercities I. as I. to item 4.	P	19a. Informant's Name/Relationship (19b. Maili	ing Address (Street			-		Zin Code)
d 2 sho d 2 sho th and 7 Is my treum		Dwayne Swauger				Oxford					
t and t and Health em 27 ther tr		20a. Method of Disposition	3011	20b. Place				Date		ition - City or	
permit. Pages 1 and 2. Department of Health at Importent: If item 27 is any injury or other tretonce.		1 Maurial 2 ☐ Cremation 3 ☐		_		osition (Name of ematory or other place		27/05			
Dattillor Dermit. Pages Department of mportent: If it any injury or o		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licer		Ceu	_	awn Mem . 2. Name and Addre					, Maryland
Dail permit. Departr Importe any inj		21. Signature of ballerar Service Elder	n n	` (11			INNICH			
		23a. Part1. Enter the disease, or com	11/1less	Me doath	20000		ilson Biv			own, N	Approximate
		shock, or heart failure. List only	one cause on each lin	ne.	1	at the mode of dys	(or respiratory arr	est,		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a_ leve	pro	2	HURRY	10				
/Medical Examiner		resulting in dealin)	Due to (or as	a consequen	ice of):	Q,					
LAGITITIO	L.	Sequentially list conditions,	b. ASI	ST	10	<u>e</u>					
D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a d insequen	ice of):						
Geath certificate be executed death certificate be executed e attending physician and dor use as the burial-transit	can	that initiated events resulting in death) Last	c Due to (or as	2 0000000000	on of):						
e be ex sician surial			Due to (b) as	a consequen	ice oi).						
of cate to the safe the the the the the the the the the th	dical		_ d								
K 00 Brtificat ling phy e as th	Me	IF FEMALE:									
ath cer ttendir or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3[Ectopic pregnancy	/		230	 Date of delimental Month 	very Day Year
e de the a	SIC	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	h 5[Other (specify)					
The Cords, P.O. BOX 00/ The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	Part II. Other significant conditions	antributing to dooth h	ut not consilting	an in the .	and orbital and an incident	on in Part I	220 Did to	bacca usa	contributo to	the cause of death?
w requires that s been signed to should be deta	b	Part II. Other significant conditions	onthoding to death b		igin ine i	andenying cause giv	enin Fanti.			No 3 □ Pro	11
w requires to been signer should be	ted	Manipoli	ie is are	YBRI	V>			101	es Zui	NO 3 FIC	obably 4 prikriowii
as bu	Completed	Hyperte	nsion					24a. Was a autop:	sv	prior to c	topsy findings available completion of cause of
The The	NO.	Dil as Pull	in shi	0				perfor 1 ☐ Yes	med? 2⊠No	death?	2 No
OI VICAL Physicien: 1 rthis certifical ral director, p	Be (25. Was case referred to medical examiner?					26. Place of Deat	h (Check only or	10)		
ysic dire	To	1 ☐ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER	/Outpatie	nt 3□ DOA Oth	er: 4 🗆 Nursing Ho	ome 5 🗆 Resid	ence 6	Other (Spec	cify)
n OI ng Phy Iter this neral d		27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	Bb. Time o	of 28c. Injur	y at k?	28d. Describe h	ow injury o	occurred	
DIVISION Tor Attending after death. Director: After	atic	2 Accident investigatio	n				Yes 2 □ No				
VIX.	tific	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At home c. (Specify)	, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and N n, State)	Vumber or Ru	ral Route Number,
rs aft	Certification;						y.				
lospi hou uner		29a. Certifier Certifying Pt	nysician: To the best miner: On the basis of	of my knowle	dge, dear	th occurred at the time	me, date and place,	and due to the c	ause(s) an	nd manner as	stated.
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	one)	and manner sta	ated.	andoni	ivestigation, in my c	рипоп, цваит оссиг	red at the time, d	ate and pi	ace, and due	to the cause(s)
Vith To t	Σ	29b. Signature and title of certifier	0 1	1		29c. Licens		1	9d. Date s	signed (Month	
		1/1/1/10	Gode	Tho.	LM	co on	05682	26 3	anu	ary	23,2005
		30. Name and address of person who	completed cause of d	leath (Item 23	a) (Type	Print)				, 0	23,2005 ,MD 2171
5H-5		William F. Boo	Lanker	ver,	90	9 Saint	Paul St	B. treet	ares	baro	1715 DM,
y St	ate	31. Date filed (Month, Day, Year)	2005 32. Registr	ar's Signatur	. 6	reded					

			For	State of Ma	-	epartment of H		lental Hygi	iene	(A) 200	0.00	- D - B-11
			1 - State Registrar		(Certificate of	Death		g. Na. U	Ub	032	07
н	Physici	an	Decedent's Name (First, Middle, L					2. Date of Deatl Month	Day	Year	3. Time of E	
	/Medic		Lewis William S: 4a. Facility Name (If not institution, g			4b City Town o	or Location of Death	January	_	005 y of Death	11:08	am
	Examin	er	20726 El Rancho			Boonsbo				hingt	on	
	Funeral			Sex 7. Age	(In yrs. last birth			8. Date of Birth (Month, Day,			lace (State or try)	Foreign
	Director		220-40-0710	¹⊠M 2□F 6	2 Y	s. Months Bays	Tiours Will.	March 2	1 1942	Ma	ryland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City	Limits
	Mary -f sho	tor	Marvland Washing	rton	Boo	nsboro					1 Tes	2∏ No
	h the	Director	10e. Street and Number	31011		10f. Zip Code		10	Og. Citizen of	What Coun	try?	
	23a c		20726 El Rancho	Road		217	13		U.S.A	١.		
	tems VI I	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		 Was Decedent of H If Yes, specify Cub. 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e		
36	rs afte	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🕅 No	Specify:		Speci	^{fy:} Whi	tο	
21215-0036	within 72 hours after death with the Maryland ene. then "neturef", or fems 23e or 28e-f show fra Modical Examilian at mast be motified at	ted	15. Decedent's	Education	16a. [ecedent's Usual Occup	pation		16b. Kind of E			
215	thin 7: e. an "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5-		Give kind of work done ife. DO NOT use retire	during most of work d)	ang				
	ed wii	Con	12	0		Supervisor		(-	Hospi			
and	be fill Hall Hall Hall of oth	Be	17. Father's Name (First, Middle, Lat	•				e (First, Middle, N		me)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Importance if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exacultational be notified at once.	은	Lewis William S 19a. Informant's Name/Relationship		19h	Mailing Address (Street	· · · · · · · · · · · · · · · · · · ·	ne Kuber		State Zin	Code)	-
<u>≅</u>	nd 2 s Ith an 27 fs :		Patricia Smith)726 E1 Ran		Boonsbo	•			- 1
	is 1 and 2 of Health a item 27 fs other trau		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other pla			20c. Location			
Ë	Page nent o nnt: ff rry or		1 XBurial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec			Haven Ceme		/05	Havers	town.	Mary1a	and
Baltimore,	permit. Page Department Important: fl any injury or once.		21. Signature of Funeral Service Lic	ensee		22. Name and Addre		Minnich 1				
_	89 E 29		Sabullille	rkin		415 E. Wil				Md. 2		- 1
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. Do no e.	t enter the mode of dyir	ng, such as cardiac	or respiratory arre	ıst,	,	Approximate Interval Betwo Onset and De	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Myel	wdrys	plustre	Lyna	drone		(som c	the
	Examiner		1	Due to (or es a	consequence of	EV.						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):						
	cuted nd ransit	Examiner	that initiated events	С.								
Ö,	ate be executed hysicien and the burial-transit	i Ex	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate b physic the b	dicai		d.						-		
9 x	death certifics e attending pt ed for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d Da	ate of delive	rv	
Вох	d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth : 4 ☐ Pregnant at		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у				Day Ye	ar
P.0.	t the c by the achec	hysi	9 Unknown	9□ Unknown								
	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying cause giv	ven in Part I.			- Committee of the Comm	e cause of dea	
ord	w require been si		- Hovel		utus	. 1		1 □ Ye	s 2 4 No	3 Proba	ably 4 ⊡Un	known
Records,	e law has b	Completed	Lurona	my Ort	ery	ansies		24a. Was ar autopsy perform	/ _	Were autop prior to con death?	osy findings av npletion of cau	railable use of
	i: The licate har.			<u> </u>					DNO P		2 🗆 No	
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2□ ER/Outp	otions of post Ott	200	h (Check only one	-	h (Ci6		
of	tanding Physician: The leath, tor. After this certificate ha tor. After this certificate ha the funeral director, page	-	27. Manner of Death	28a. Date of Injur	v 28b. Tir	ne of 28c. inju		ome 5 Reside		her <i>(Specify</i> rred	7	
ion	Attanding r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day ion	rear) inj		Yes 2 □ No					
Division	r Atta ier de irecto	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju	ry - At home, farr . (Specify)	n, street, factory, office		28f. Location (Str. City or Town		ber or Rurai	l Route Numbe	ЭГ,
	urs aff											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and	death occurred at the ti or investigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and m ite and place,	anner as sta and due to	ated. the cause(s)	
	o the	Mec	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signe	ed (Month, L	Day, Year)	
)	F \$ F 0		Harden 1		1 1	1 7	27723	T	· · · · · · · · · · · · · · · · · · ·	. 21	ZIHL	
			30 Name and address of person wh	o completed cause of de	oalh (Item 23a) (T	ype, Print)	, , ,		V4	1	1,000	1
2	1-6		Grederic 14	· LASS T	[. m.	11110 h	edicel	Carps	15%	ltege	18 trun	s mi
	Sta		31. Date filed (Month, Day, Year)	2005 32. Registra	r's Signature	Coartes				'		
	Registi	वा		100000	10.							

			1 _ For	State of	Maryland / De		Health and	Mental Hygier	5005	03208
			Registrar 1. Decedent's Name (First, Middle	, Last)		or timeate of	Dealli	Reg. N	16: 000	3. Time of Death
	Physici		Arlynn Leroy S	HAFFER					ZZ ZOS	4
	/Medic Examir		4a. Facility Name (If not institution		er)	4b. City, Town,	or Location of Deat		c. County of Death	
		- 2	Washington Cou				rstown		Washingt	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	y) If Under 1 Year Months Days		(Month, Day, Yea		place (State or Foreign ntry)
	Director		723-07-9578 Usual Residence of Decedent		75			Feb. 18 1	929 ∣Penr	nsylvania
	ryland	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	8a-f s	Funeral Director		ington	Hage	rstown				1 ☐ Yes 2 🔯 No
	a or 2	급	10e. Street and Number			10f. Zip Code		10g. C	litizen of What Cou	ntry?
	ns 23	eral	17003 Oakleigh	12. Was Decede	ent Ever in U.S. 1		21740 Hispanic Origin? (S	pecify Yes or No-	U.S.A.	can Indian
ပ္	or Iten	Fun	1 ☐ Never Married 2 ☐ Marri	Armed Force	∍s? ☑ No	B. Was Decedent of If Yes, specify Cub		o Rican, etc.)	Black, White,	
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Examinations Le notified at	d by	3 Widowed 4 Divorced	If Yes, Give- Year or Date	os:	1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
15-(be filed within 72 ho ital Hygiene. id other than "natur avent, the Medical	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. De	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of wor	rking 16b.	Kind of Business/Ir	ndustry
12	within lene. than "	duc	Elementary/Secondary (0-12)	College (1-4	or 5+)	Conducto			ailroad	
d 2	a filed of Hygie other t	Be C	17. Father's Name (First, Middle,			Conducto		ne (First, Middle, Maide		
Maryland	should be nd Mental marked o	To B	Leroy Samuel S	haffer			Elva Hu	ıtzell		
lan	S S S		19a. Informant's Name/Relationsh			15		ıral Route Number, City		,
	itam 27		Betty Shaffer	- Wife	17	003 Oakle	igh Way,	Hagerstown		
Baltimore,	0 = 5		1 X Burial 2 Cremation	3 Removal from Sta	110	position (Name of rematory or other pla			Location - City or T	own, State
Ħ			' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I			awn Mem.		3/05 Ha Linnich Fun		Maryland
Ba	permit. Departr Importe any inje		+ 30 A 74	1000	/ /			l. Hagerst		
I	7.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau						Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	Rot					1500	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):		1010	inacció c	200	
	LXummer	<u></u>	Sequentially list conditions:	b. 1) 16	as a consequence of):	Mitin.	+//w.	Tentur D	and the same of	
	nsit	nine	Sequer tially list non-ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (U/	as a consequence on).		CV			
Ć.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
1760,	e X	ical		d						
68	death certificat e attending phy d for use as th	Physiclan/Med	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	Ectopic pregnanc	у	7	23d. Date of delive Month	ery Day Year
0.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow		Other (specify) _				22,
s, P.	de de		Part II. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
rds	quires on sign uld be	ed by						1 [X] Yes	2□No 3□Prot	bably 4 Unknown
Record	aw requir is been si 2 should	ompleted						24a. Was an	24b. Were auto	psy findings available
R		Com						autopsy performed? 1 ☐ Yes 2 🛣 N	death?	mpletion of cause of 2□ No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Harakalı				th (Check only one)		
of	S 0 0	P	1 X Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpa	atient 2 ER/Outpati			ome 5 Residence		ý)
no	ding h. After fune	tlon	1 Natural 5 ☐ Pending	(Month,	Day Year) 200. Time	Wo	ryat rk? Yes 2 ∐No	28d. Describe how inju	ary occurred	
Division	deat deat ctor: / the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At home, farm,			28f. Location (Street a		al Route Number,
Ö		Certification	4 🗍 Homicide	building,	etc. (Specify)			City or Town, Sta	(e)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical 8	Physician: To the be xaminer: On the basis and manner	est of my knowledge, de s of examination and/or stated.	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the cause(rred at the time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)
	To the P within 24 To the F complete	M	29b. Signature and title of certifier	0.4		29c. Licens	se number	29d. D	ate signed (Month,	Day, Year)
ĽÜ.			Tolor in l W	WHOT	アバン	1)0	-106 I	Ja	u 22,	2003
	H-10		30. Name and address of person v	~ 11	of death (Item 23a) (Typ	e, Print)	()	Ja ne RE A	agers tou	on, MI)
		10	31. Date filed (Month, Day, Year)) itto til			d Terro	ie he	21747	
100	Sta Registr		JAN 24	2005 32. Begi	strar's Signature	1				
DHI	MH 17 Rev 1/20	201		- day	All of	The state of the s				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Yeer Arlene Bertha Sheeley Januar 20 200. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😡 F Director 85 Yrs 216-14-5696 Oct. 8,1919 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1175 Proffesional Court Items 23e 21740 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ent: If item 27 Is marked other than "naturel", or Items 23s Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Edward H. Baker Mary E. Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent; If item 27 Is eny injury or other treuonce. Kay Reel
20a. Method of Disposition (Daughter) 16514 Virginia Avenue Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State Greenlawn Mem. Park Jan. 25,2005 *4 Denstion 5 □ Other (Specify) Williamsport, Maryland Signatur Funer Perice Li 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 St. Williamsport, Maryland shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hemoirhagi-**Physician** erebral disease or condition resulting in death) hours /Medical Due to (or as a consequence of) **Examiner** hypertension Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🙀 No Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1eZiNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicef Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058195 January 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Tu Bui

31. Date filed (Month, Da)

Williamspier, MD

32. Registrar's Signature

3 Byrkit Dr.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** January 17 Doris Lucille Sprecher 2005 10:00PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Williamsport Nursing Home Williamsport
If Under 24 Hrs. 8. Date of B.
Hours Min. (Month, D Washington County If Under 1 Year Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Months 86 Yrs. Nov 15 1918 Maryland Director 220-18-0122 with the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show d 2 should be filed within 72 hours efter death with the Maryle th end Mental Hygiene.
It is marked other than "naturel", or flems 23a or 28a-f shor traumstic event, the Medical Examiner must be notified at Yes 2 No Directo Maryland Washington Williamsport 10e. Street end Number 10a. Citizen of Whet Country? 10f. Zip Code 40 East Village Lane 21795 United States Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook 12 Restaurant permit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Long Daisy Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Tina M. Forsythe 1111 Moller Ave. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park 1-21-05 Williamsport MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityDouglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd.N. Hagerstown MD 21742 10 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical RENAL FAILURE ON CHRONIC YEARS Examiner Due to (or as a consequence of): Examiner YEARS ATHERO SILEROTIC VASCULAR or Attending Physician: The lew requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown CEREBROVASCULAR DISTASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed CEREBRAL INFARCTS 1□ Yes 2⊠No 1 ☐ Yes 2 ☐ No EMPHYSEMYS Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4M Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this Director: After the 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 StNatural
2 Accident 5 Pending death. investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1)33700 JANUARY 18, 2005 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) N. ARTIZAN 2H-3 MD. WILLIAMSPORT HOWE Ei 51 IED 31. Date filed (Month, 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

amend item#19a, per INF (840, 2) //05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 25, January 2005 Rodney Bruce Sally 8:45 p.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∰**M 2□F Hours Min. Yrs. Director 60 347-34-4375 June 27,1944 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Examiner mans to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director St. Mary's Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45075 Nalley Road Funeral 20636 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No 1961-1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 € No Specify: White Specify: ģ 3 Widowed 4 Divorced 1965 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Aircraft Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Arthur Sally Nina Sylvesta Davis 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janey Claire Sally / Wife 45075 Nalley Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 1-28-2005 | Charlotte Hall, MD 21. Signature of Greenal Sept concensee

Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Lung Cancer & Metastic Disease 1 Month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) d be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown plnods Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 X No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No Accident **Director:** 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005 32. Registar's Signature

Rajbinder S. Gill, M.D., Shah Associates, Hollywood, Maryland 20636

29c. License number

D56096

29d. Date signed (Month, Day, Year)

STAUFFER

DEAN

RODNEY

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			Registrar 1. Decedent's Name (First, Middle, Las	4)		illicate	OIL	Jean		2. Date of De	Reg. No.	_ 0 0	U	3. Time of Death
	Physici	an								Month	Day		ear	11112 11 112
	/Medic Examir	cal	4a. Facility Name (If not institution, give	Shepherd, Sr.		4b. City, T	Fown, or	Location o		Januar		County of	005 Death	7:13 A ^M
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	Funeral		Social Security Number 6. Security Number	TH 2DE		If Under 1	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Da	th	9	. Birthpl	lace (State or Foreign
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	itam Itam	- CI	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	.3.	If Yes, speci	fy Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	,		White, e	
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0	ld be lenta kad kad ic ev	To B	Tyler Shepher	d						Franl	kie M	. Per	rry	
5	shound N	P==	19a. Informant's Name/Relationship (7		19b. Maili	ng Address	(Street a	and Numbe	r or Rura	A Route Numb	er, City or	Town, Sta	ate, Zip	Code)
Ž	nd 2 allth a 27 Is		Sheila Chavis-Sh	epherd / Wife	11	309 Bi	irkd	ale C	t.,	Mitche:	Llvil	le, 1	MD	20721
נֿע	permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 Is marked other than *natural; or itams 23e or 28e-f show amy righty or other traumatic event. I'm Medical Excinding multipe indiffical at ODGs.		20a. Method of Disposition		Place of Dispo	osition (Nam	e of her place	a)		Date	20c. Lo	cation - Ci	ty or To	wn, State
2	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	-			1/2	1/2005	C	helte	nha	m, MD
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ă	Depariming Department Important in any ir sonce.		PARA T.	Terrory II	1- 1	4001	Benn	ning l	Rd.,	N.E. V	lash.	, DC	200	19
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	Distriction		shoot it r heart failure. List only o	one cause on each line. Pancreatio	Cance	ar								Onset and Death 2 Years
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	To the Hospital or Attanding Physician: The law requires that the death certific Within 24 hours after death. To tha Funaral Diractor: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	ysicien: To the best of my kno iner: On the basis of examina	wledge, deat tion and/or in	h occurred a	t the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s)	and manne	er as sta	ated. the cause(s)
	the I	Medi	one) 29b. Signature and title of certifier	and manner stated.				number	_			signed (A		
	Z Z S		250. Signature and title of certain	80.0	(3)	200.	1	821	9					
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)	SP		30. Name and address of person who described and start of person who described as the start of t		^{1 23а)} (Туре. Метса:		Land	a. Tas	ran	MD 20	774			
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 14, Steven Sarelas 2005 Dunn 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 18, 1 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 1**⊠**M 2□F Yrs Washington, DC Director 213-54-6204 47 1957 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5476 Cedar Lane #C2 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 TN Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Security Marriot Corp. / Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nicholas Sarelas Dolores Headrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 soft Health and Item 27 is Thomas Sarelas / Brother 17705 Comus Road, Dickerson, Maryland 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation = 5 □ Other (Specify) Gate of Heaven Cemet 01/19/2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Senoter 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a con-equince of) Examiner The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): attending physiclan for use as the burial Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe rmed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onlone Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2153 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pushkas Old Georgetown Rd Rockville reter G 31. Date filed (Month, Day, Year) Registrar's Signature State 9 2005 Registrar

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			1 - For State Registrar	State of M	/larylan		artment of rtificate o			Reg. N	200	5 0	321	5	
	Physicia /Medic		1. Decedent's Name (First, Middle, Rober	. Last) ct Lee Simo:	ns				2. Date of Month	D	7, 200	'ear	ime of Dea	ath M	
	Examin		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town		of Death	4	c. County of	Death			
			Citizens Nurs				Fred	erick ar If Under	24 Um	1000	Frede				
	Funeral Director		5. Social Security Number 220-09-9305	6. Sex 7. A	Age (In yrs 87	last birthday) Yrs.	Months Day		Min. (Month	14, Day, Yea	1)	Birthplace (S Country)		reign	
			Usual Residence of Decedent		0/				July	14,	1917	Maryla	na		
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. I Hygiene. I har insture!, or items 23e or 28e-f show ent, it e Medical Evar in at must be twitter; at	Completed	15. Decedent' (Specify only highes			(Give	dent's Usual Occ	ne during mos	t of working	16b.	Kind of Busi	ness/Industry			
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an	ld be lental ked c	To Be	Robert Milton	Simons				Lil	llie Cath	therine Metz					
Maryland	shou and M s mar	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stre	et and Numbe	er or Rural Route N	umber, City	or Town, St	ate, Zip Code,)		
Σ	and 2 salth a n 27 is		John B. Simons	s Son		Rou	te 1, B	ox 440	Harpers	Ferry	, WV 2	5425			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural; or tems 23a or 28a-f show any injury or other traumatic event, it a Medical Ever it rules be a ratified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from Stat		Place of Dispo semetery, crea	sition (Name of matory or other p	olace)	Date	20c.	Location - C	ity or Town, St	ate		
Ë	. Pag tment tent: tent:		*4 □ Donation 5 □ Other (Sp	pecify)		_	wn Crem		1/21/200		_	wn, MD			
Ba	permit Depar Impor Impor any In	İ	21. Signature of Funeral Service L	icensee / //		22	2. Name and Add	dress of Facilit	· VIIII						
	20200		23a. Part1. Enter the disease, or	complications that caus	ed the deat	h. Do not ent	er the mode of o	tving such as	Brunswi		D 21/1		oximate	-	
	Dharainian		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	+				_	10 .	Interv	al Between		
	Physician /Medical		disease or condition resulting in death)	a Due v (ou	conseq	uence of):	rent	Chris	o ilasoch		Luse	0	yr	7	
	Examiner		Conventially list conditions	b. ===		,									
	p #	iner	Sequentially list conditions, any, leading to transcript cause. Enter Underlying Cause (Disease or injury		peanoa e as	uenou of):									
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	25 2 000000	uence of):									
8760,	be ey iician buria			500.10 (61.0	13 & 00/130Q	donos dij.									
687	flicate g phys	Physician/Medical		d											
Вох	death certific e attending p id for use as i	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			75				23d. Date	of delivery			
œ.	0 0 0	sicia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of d		<pre>JEctopic pregna JOther (specify)</pre>			_	Month	n Day	Year	1	
P.0	that the de led by the a detached i	Phys	9 Unknown												
ŝ	og og	þ	Part II. Other significant condition	7 11/ -		ulting in the u	nderlying cause	given in Part I.		Did tobacco	11	ute to the caus			
0.0	w requir been si should I	eted	10 .1 1	m of						-	<u> </u>				
Vital Records,	has l	Completed	Nec suls	Mexico	5					Was an autopsy performed2	pric	ere autopsy fin or to completio ath?	dings avail in of cause	able e of	
	(0 ==	e Co	25. Was case referred to medical					00 Di	1 🗆 Y	es 2		Yes 2	0		
Ξ	tending Physicien: Beath. tor: After this certific the funeral director,	To Be	examiner?	Hospital: 1 Inpa	ntient 2□	ER/Outpatier	nt 3 DOA	Thor 1	of Death (Check of Irsing Home 5		6 Other	(Specify)			
J Of	ding Phy h. After thi funeral c		27. Manner of San	28a. Date of In		28b. Time o	f 28c. In	ijury at Vork?			jury occurred			_	
0	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending investig	ation	-, ,	мушту		☐Yes 2☐	No						
Divislon	I or Attendeatl	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Flace of 1	Injury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, offic	Э		ion (Street a r Town, Sta		or Rural Rout	e Number,		
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by		29a. Certifier 1 Certifyin	a Physician Tathat	et of my l-r	nudad== -t- ::		sima de	delega d i i	the	(a) as 3				
	e Hos 24 hc e Fun etely	edicai	(Check only one)	g Physician: To the bes Examiner: On the basis and manner:	of examina	tion and/or in	n occurred at the vestigation, in m	y opinion, dea	th occurred at the t	ime, date a	nd place, an	d due to the ca	use(s)		
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	11			29c. Lice	ense number		29d. D	ate signed (Month, Day, Y	ear)		
}			> X ship	1. Karl	nem	~	10-	-139	71		1/201	05	-		
	(6)		30. Name and address of person in	who complete suse of	f death (Iten	n 23a) (Type,	Print)		-		1 1				
			ROBERT L KAL	FMANIN			INTH S	T. FRE	MERKK	MD.	217	101			
	Sta Registr	-	31. Date filed (Month, Day, Year)	1 2005 32. 30	strar's Signa	De S	and of								

				partment of Health and Menta	al Hygien	2005 00016
				ertificate of Death	Reg. No	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Mo	onth Da	
П	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		8, 2005 10:14 PM
ē	Cxamii	er	102 Foxboro Drive	Risina Sun		Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	() If Under 1 Year If Under 24 Hrs. 8, Da	te of Birth onth, Day, Year	9. Birthplace (State or Foreign
	Director		058-58-7551			935 England
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary Feb	ţ	MD Cecil Rising	Sun		1 ☐ Yes 2 🛣 No
	or 28e	irec	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
	23e (raiD	102 Foxboro Drive	21911	us	4
	er des	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,	etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by Funeral Director	1 □ Never Married 2 📉 Married 1 □ Yes 2 🖔 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specity:		Specify: White
ŏ	72 hours after death with the Maryland Insturel', or Iteme 23e or 28e-f ehow disel Exactinet must be notified at	ted	15. Decedent's Education 16a, Dece	edent's Usual Occupation	16b. F	Kind of Business/Industry
215	within 7 ene. then "n the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		
2	e filed within al Hygiene. I other then '			maker		1 Home
Maryland 21215-0036	uld be fil fental H rked otl ic even	Be	17. Father's Name (First, Middle, Last) Ernest Mason	18. Mother's Name (First,		n Sumame)
Ž	should nd Men marke umatic	ဥ		Ing Address (Street and Number or Rural Route		or Town State Zip Code)
Z	d 2 th a 7 is			Foxbero Drive, Risino		
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		20a. Method of Disposition 20b. Place of Disp	position (Name of pate of pate of pate)	20c. L	ocation - City or Town, State
<u><u>E</u></u>	permit. Page Department o Importent: If eny injury or once.		'4 □Donation 5 □Other (Specify) R.T. Fow	rd Funeral Home. P.A.	Ri	sing Sun. MD
alt	permit. Departrimports Imports any injuge.		21. Sometime of Funeral Service Licensee	22. Name and Address of Facility R.T. Fo	pard Fur	reral Home, P.A.
	20529		Juchard L. Jorque 1	11 S. Queen Street, Ri	ising Su	in, MD 21911
			23a. Part1. Enter the disease, or complications that caused the death. Do not en spock, or heart failure. List only one cause on each/line.		ratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Welcas (each resulting in death)	ic Ling Cancer		
	Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000		
28	cuted nd ransit	Examiner	that initiated events C.	l Versculon d	liea	ne.
8760,	sate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a con equence of):	I versculou de	c 0	
387	physic the b	dical	d Corono	or being on	1000	2
Box 6	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
ĕ.	death e atte	icia	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	the by th ache	hys	9 ☐ Unknown			
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23		use contribute to the cause of death?
ord	requir	ted			1 ☐ Yes 2	No 3 Probably 4 Unknown
of Vital Records,	faw as b 2 s	Completed		24	la. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
al	Tage Tage		OF West and the state of the st		JYes 2. VN	
₹	Physicien: this certificanal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Checonnumber 1) 26. Place of Death (Checonnumber 2) 26. Place of Death (Checonnumb		6 COther (Specify)
ı of	g Phy er this ieral c		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Do	escribe how inju	
ion	Attending I r death. sctor: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	if or Attend after death Director: / I in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		cation (Street a. ty or Town, Stat	nd Number or Rural Route Number, e)
	pitel o		CO- Continue of Continue Sharing To the best of an In-			
	e Hospitel 24 hours a e Funerel l etely filled	Medical	29a. Certifier 1 ☑ Certifying Physicien: To the best of my knowledge, dea (Check only one) 2 ☐ Medicel Examiner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and place, and du nvestigation, in my opinion, death occurred at the	e to the cause(s ne time, date an	d place, and due to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
) (hrsae e m	D0026183	1-	19-05
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)		
			322 E. Cec. Ave. North East 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, md 21901 - Dr	1 MADIN	10 SAchder
	Sta Registr		JAN 2 0 2005	And .		
			W. W. D. COOL TOWNERS P. S.			

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H	lealth an Death	d Mental Hyg	iene2 () (05 (03217
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day		3. Time of Death
	Physici /Medio		Dan Stevens					Januar		Year 2005	9:45 a ^M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of D	Death	4c. County		
			2204 Harley Dri				nkirk			1vert	
ľ	Funeral		5. Social Security Number 6. Sex	7. Ag	(In yrs. last birthday)	If Under 1 Year Months Days		Vin. (Month, Day,	Year)	9. Birthplace Country)	e (State or Foreign
	Director		213-56-6265 Usual Residence of Decedent		53 Yrs.			6/29/1	.951		DC
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
	Mary -f sh	ō	MD Calve	rt		Dun	kirk				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code	INTIN	1	0g. Citizen of W	/hat Country?	?
	13e o		2204 Harley Dr	ive		207	54		US	: Z	
	deat	Funeral		2. Was Decedent Amed Forces?	Ever in U.S. 13.			? (Specify Yes or No- uerto Rican, etc.)	14. Race	- American	
ဖွ	after or Ite	교	1 Never Married 2 Married	1 Yes 2 1	10	1 ☐ Yes 2 X No		derio Rican, etc.)		k, White, etc.	
003	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Exame or must be tradified at	d by	3 Widowed 4 Divorced	Year or Dates:		12.103 2,2,110	Spoony.		Specify:	Wh	ite
<u>7</u>		Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of	working	16b. Kind of Bu	siness/Indust	try
12	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	uck Dri	•		Фил	ckind	•
2	e filed within al Hygiene. i other then ' vent, the Me		1.2 17. Father's Name (First, Middle, Last)		1.1.	uck DII		Name (First, Middle, A			j
an	d be ental	To Be	Theodore Sapo	uekv				th Elizab			1
Maryland 21215-0036	as 1 and 2 should be lof Health and Mental I item 27 le marked or rother treumatic eve	-	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street		or Rural Route Number,			
	nd 2 alth a 27 le		Deborah Stevens	/Wife				e, Dunkir			
ē,	ges 1 a t of Hea If item or othe		20a. Method of Disposition		20b. Place of Dispo cemetery, cre				20c. Location - (
E	Pages nent of int: If it iry or o		1 X Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)	emoval from State		norial G		/29/05 D	unkirk	, MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	90				Raymond-	Wood F	unera	al Home
Ω_	80 = 80		C. Wor					unkirk, M			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not en	ter the mode of dyin	g, such as car	diac or respiratory arre	est,	Ap Int	proximate erval Between
	Pnysician		Immediate Cause (Final disease or condition	metas	tahe nanoma	I cell lung	cancer				set and Death
	/Medical Examiner		resulting in death)		a consequence of):	,					
	LAMITHIE		Sequentially list conditions,								
	ed isit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):					- 1	
	and and II-trar	Exami	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai E		,							
687	ficate p physis ts the	edic									
Вох	eath certific attending p	Z/	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome		-			23d. Date	of delivery	
	death	cia	in the past 12 months?	4□Pregnant at		∃Ectopic pregnancy ∃ Other <i>(specify)</i>			Mon	_	y Year
P.0		Physician/Me	9 🗆 Unknown	9□ Unknown							
	The law requires that tte has been signed b age 2 should be deta	by F	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		acco use contri		
Records,	w require been si should b	ted						1 <u>□ Ye</u>	s 2 🗆 No	3 🗌 Probably	4 □Unknown
ec	law re as be 2 sh	Completed						24a. Was ar	24b. W	ere autopsy	findings available
<u>~</u>		Con						perform	red? de	eath? □Yes 2□	
Vital	Physicien: T this certificat al director, pa	Be (25. Was case referred to medical examiner?				26. Place of	Death Check onl one	9		
of \	Physi this c	2	1 195 2 190	ospitai: 1 ☐ Inpatie			4 INUISII	ng Home 5 - Reside			
	ing After une	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time o Injury	Work	k?	28d. Describe ho	w injury occurre	ed	
isic	en or:	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Init	us. At home form at		Yes 2 □ No	296 Launting /Cts	and himba		
Division	ol or Attend after death Director: , d in by the f	Certification:	4 Homicide determined	building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str City or Town	, State)	r or Hurai Ho	oute rvumber,
	spite		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge deat	h occurred at the tim	ne date and n	lace, and due to the ca	usa(s) and mar	ner as stater	
	To the Hos within 24 h To the Fur completely	ledical	(Check only 2 Medical Examir one)	er: On the basis of and manner sta	examination and/or in	vestigation, in my of	pinion, death o	occurred at the time, da	ite and place, a	nd due to the	cause(s)
	To the within 2 To the complet	₹	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed	(Month, Day	, Year)
) autel			DS	45024		Januar	, 24 8	2005
	П		30. Name and address of person who co								
	1		Kenneth Abbott	, M.D.	l10 Hospi	tal Roa	d #110), Pr. Fr	ederic	k, MD	20678
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	a Signature					-	
	Registi	ar	JAN ~	- 4000	Bour &	GOBALL)	9				

			For State Registrar	State of N		artment of Health rtificate of Death		giene 005 03	218
			Decedent's Name (First, Middi	e, Last)			2. Date of De		e of Death
п	Physicia		Richard	Corley	Standle	ey	January	Day Year 7 20, 2005 5:	м q 0
	/Medic Examin		4a. Facility Name (If not institution	n, give street and numbe	r)	4b. City, Town, or Location		4c. County of Death	30 P
			Calvert Memor:	ial Hospital	L	Prince Frede	rick	Calvert	
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last birthday)			h 9. Birthplace (Sta	ate or Foreign
	Director		356-56-8874	1 M 2 □ F	44 Yrs.	Worturs Days Frours	June 2	8,1960 Nebraska	L
	pu k	}	Usual Residence of Decedent 10a. State 10b, County		10c. City, Town or Lo	noation		10d tesid	e City Limits
	Aaryla sho	5			,				Yes 2 TYNo
	the N	ect	MD Calve	ert	Prince Fr	10f. Zip Code		10g. Citizen of What Country?	AV.
	with le or		1630 Lottie Fo	wler Road		20678		U.S.A.	
	leath	era	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.		rigin? (Specify Yes or No		n.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumetic event, the Modical Examitment usit be multified at	by Funeral Director	1 ☐ Never Married 2 💆 Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed Force: 1 XYes 2 If Yes, Give	s? □ № s: 1980–81	Was Decedent of Hispanic On If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☒ No Specify		Black, White, etc. Specify: white	
ŏ	2 hou	ted		it's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/Industry	
215	hin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4c	life	kind of work done during mo DO NOT use retired)	st of working	•	
21	giene giene er the	mo:	12	0011090 (1 40		isabled		none	
ğ	be filed ital Hygi d other event,	Be (17. Father's Name (First, Middle,	•		18. Moth	er's Name (First, Middle,	Maiden Sumame)	
Baltimore, Maryland 21215-0036	2 should be and Mental is marked creametic even	Jo.	William	Stand.	ley	Ca	arol u	nknown Seymour	
Nar	2 shot and is m		19a. Informant's Name/Relations					er, City or Town, State, Zip Code)	20.670
6,	l and lealth am 27		Helen Standle	y, wife	20b. Place of Dispo		Date	e Frederick, MD	
יסר	ages or of	- 13	1 ☐ Burial 2 🛱 Cremation		te cemetery, cre	matory or other place)		20c. Location - City or Town, State	8
뜶	it. Partment	1	4 □ Donation 15 □ Other (S	_ ''I		tan Crematory 2. Name and Address of Facil		Alexandria, VA	
Ba	permit. Pages 1 and Department of Healt Importent: If item 2 any njury or other once.		Deya!	Tulea	ih Ri	ausch Funeral	Home, P.A.,	Owings, MD 2073	36
П			23a. Part1. Enter the disease, o shock, or hear failure. Lis	only one cause on each	line.		s cardiac or respiratory ar	Interval	mate Between and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alco	holic Hy	patitis		5 ye	445
	Examiner		, , , , , , , , , , , , , , , , , , ,	Due to (or a	as a consequence of):	M		10,1	uk
		e.	Sequentially list conditions,	b. De to (or :	as a consequence of):				nerk
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	5 50	PSIS			1 4	reck
ó	an an		resulting in death) Last	Due to (or a	as a consequence of):				•
8760,	cate be executed physician and the burial-transit	dicai		d					
9	n certific anding p use as		IF FEMALE:	220 If year outpean	no of prognancy				
Вох	ath utte	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day	Year
o <u>i</u>	that the de led by the a detached t	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	- 9□ Unknown		Other (specify)			
٣	requires that the een signed by th hould be detache		Part II. Other significant conditi	ons contributing to death	but not resulting in the u	underlying cause given in Part	I. 23e. Did to	obacco use contribute to the cause	of death?
Vital Records	quires n sign uld be	ed by	Hypubil	i Rubine	min-		1 🗆 1	es 2 No 3 Probably 4	□Unknown
000	> 0	piet	ASCIL	les			24a. Was		ngs available
R	: The lav cate has	Completed					autop perfo 1 ☐ Yes	prior to completion death?	of cause of
ita		ø	25. Was case referred to medica	1		26. Plac	e of Death (Check only o		
	dis y	To B	examiner? 1 Tes 2 No	Hospital: 1 Impa	itient 2 ER/Outpatie	nt 3 DOA Other: 4 N	ursing Home 5 Resid	dence 6 Other (Specify)	
n of	ng Ph fter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of Ir (Month, I	njury 28b. Time o	of 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sio	Attanding r death. sctor: After	catl	2 Accident invest	igation		M 1 Yes 2]No		
Division	of or Attano after death Director:	Certification;	3 Suicide 6 Could 4 Homicide deterr	nined 286. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number or Rural Route I vn, State)	Number,
_	pital ours a nerel l		29a. Certifier 1 Certifyi	ng Physician: To the he	et of my knowledge, door	th accurred at the time, date o	ad along and due to the	cause(s) and manner as stated.	
		ca	(Check only one)	Examiner: On the basis and manner	or examination and/or in	nvestigation, in my opinion, de	ath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cau:	se(s)
	ne Hou 1 24 h ne Fur	Ď				29c. License number		29d. Date signed (Month, Day, Yea	1
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical	29b. Signature and Ale of Certific	11111		_			17)
)	To the Hor within 24 h To the Fur completely	Med		MAG DE		H0037	22 8 mp	1/21/05	
)	To the Hor within 24 h To the Fur completely	Med			f death (Item 23a) (Type,		22 8 m D	1/21/05	
	3+1	M	30. Name and address of person Stephen P. Ca	fferty, M.D	., 135 W. D	, Print)		ce Frederick, M	
6.5	To the Hor within 24 h within 24 h To the Fur completely	N te	30. Name and address of person Stephen P. Ca	fferty, M.D	., 135 W. D	Print) ares Beach Rd.			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 13 2005 9:19 PM January William E. Sims 4a Fecility Name (If not institution, give street end number) /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel 19 Romar Drive Annapolis If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⅓**M 2□ F Months Days 259-09-1308 86 July 8, 1918 Georgia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Romar Drive Funeral 21401 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Naval Officer U.S. Navy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Cheshire Sims မ Dora Hilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Prive Annapolis 41 21401 20c. Location - City or Town, State Martha Sims/ wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Jan. 17, 2005 Baltimore MD 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensee Olum 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE 3 YEARS YEARS AORTIC VAlve Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as e consequence of):

g physician and as the burial-transit Attending Physician: The law requires that the death certificate be executed for use as the certificate has To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complately filled in by the f

Division of Vital Records, P.O. Box 68760,

Funeral

Director

r 28a-f show

Hygiene. other than "natural", or flems 23a or ? ent, the Medical Examiner must be !

of Health and Mental Hygie I Item 27 is marked other to other traumatic event, In

of Health a

Department if

Physician /Medical

Examiner

Injury

filed within 72 hours aftar death with the Maryland

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner Medical Certification: To

Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death
CORONARY	ARTER	Y Dis	ease	1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☐ Unknow
Chronic 1	Renal F	Ailure	>	24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 Yes 2 3 10	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner?	ospital: 1 🗆 Inpatient 2 🗆	☐ ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Hesidence 6 ☐ Ott	ner (Specify)
27. Menner of Deeth 1 ☑ Meturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, fac fy)	tory, office	28f. Location (Street and Num. City or Town, Stete)	ber or Rural Route Number,
29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the cause(s) and mo curred at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d. Date signe	ed (Month, Day, Year)

D 27388

MD 21401, A. Stephen HANSMAN

State Registrar 31. Dete filed (Month, Day Year)

JAN 18 2005 ROAD #303,

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

. Registrer's Signature

ORIGINAL

			For State Registrar	State of Ma	ryland	/ Depa		of H	ealth a		_	/	005	03220
			Decedent's Name (First, Middle, Las	t)			timodito		Journ		2. Date of De	Reg. No.		3. Time of Death
	Physicia			hultz							Month January	Day	2005	5:45P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of	of Death	Januar	-	ounty of Deat	
	Examin	er	Genesis Eldercare		own		Randa			., 500		1	ltimor	
	Funeral		5. Social Security Number 6. Se			st birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th		hplace (State or Foreign
	Director			X M 2□ F	84	Yrs.	Months	Days	Hours	Min.	Jan. 7	y, Year)	Co	nsylvania
			Usual Residence of Decedent											
	ylan how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Ma Ma	cto	Maryland Baltimor	re e	Randa	allst	own							1 ☐ Yes 21 No
	or 28)ire	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	ountry?
	23a	Funeral Director	9109 Liberty Road	1			2113	33				USA		
	swe swe	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	. 13. \	Was Deced	ent of His	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	Race - Ame Black, White	
9	or H	y Fu	1 Never Married 2 Married	1 XYes 2 □ N			1 □ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,		nacihe	
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates: V									WII.	ite
ζ.	within 72 hours after death with the Maryland ene than *natural", or Items 23a or 28a-f ehow fre Modice! Exertifue resat be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	dent's Usua <i>kind of wor</i> DO NOT us	k done d	ition <i>Juring</i> mos	t of work	ing	16b. Kind	d of Business/	Industry
12	withir ane. than	m d	Elementary/Secondary (0-12)	College (1-4or 5-	+)		pente		,			Con	struct:	ion
2	Hygie Hygie ther nt, tr		17. Father's Name (First, Middle, Last)			Car	Jence		18 Mothe	ır's Namı	e (First, Middle,			1011
au	ad be land) Be	Charles Edward Sh								nnelly	101000110	umamoy	
2	houk d Me mark matik	2	19a. Informant's Name/Relationship (7			19b Mailir	na Address	(Street a			al Route Numbe	or City or	Town State	Zin Code)
Maryland 21215-0036	d 2 s Ith ar 27 is trau		Marilyn A. Shultz								Annapol	-		•
စ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Extractive rest by notified at once.		20a. Method of Disposition		20b. Pla	ce of Dispo				Jani			ation - City or	
ē	ages int of t: If i		1 ☐ Burial 2 【XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	1				- 1		-	Odon	ton M	awrr1 and
Baltimore,	nit. P artme ortan injury		21. Signature of Funeral Service Licen		W .	AI unu	ST CI	d Addres	ory :	1/,	2004			aryland
Ba	Depire Impo		1 Borel St	Felt	M018	5/ G	oing leverl	Home y L.	Crem Heck	atio	n Serv	ice Cla	P.O. Borksvil	ox 784 le, MD 21029
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. e.	Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	SEI	25	S								Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a		,	٠.							
	Examine		Sequentially list conditions,	0.		3	INC	M						
	pe sis	Examiner	Sequentially list conditions, if any, leading to immediate cause. First linearlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):								
	and -tran	хап	that initiated events resulting in death) Last	cDue to (or as a	CORROGUE	ance of):				···	-			
8760,	ate be executed hysician and the burial-transit	ical E		200 10 (01 00 0	a comocque	1100 017.								
87	phys phys the	dici		d										
9 X	The law requires that the death certifics ate has been signed by the attending ploage 2 should be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	cv						22	d. Date of del	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal c	death 3□	Ectopic pro					23	Month	Day Year
P.O.	the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		0_	1 Other (Sp.	y/						
	res that igned by be deta	Y P	Part II. Other significant conditions of	ontributing to death bu	ıt not result	ting in the u	nderlying ca	ause give	n in Part I		23e. Did t	obacco use	e contribute to	the cause of death?
Records,	uires sigr	d by	DEMENTI	A; PR	OST	975	- C#	W(ZR		1 🗆 '	Yes 2	No 3□Pr	obably 4 Hinknown
Ö	w require been si should l	Completed		1						•	24a. Was	an	24h Were au	itopsy findings available
Re	The law cate has page 2 s	Ę.									auto	osy ormed?	prior to death?	completion of cause of
Vital	i cian : Th certificate ector, pag		25. Was case referred to medical			-			00 81		Yes Yes	2□ No	1 U Yes	2X No
⋚	Physician: r this certifica ral director, p	o Be	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 ☐ Inpatie	nt 2□E	R/Outpatier		Othe	0.61		h <i>(Check only d</i> me 5 □ Resi		Other (Co-	-if.il
o	Phy r this aral d	. To	27. Manner of Death	28a. Date of Injur	y 2	28b. Time o		8c. Injury Work		irsing no	28d. Describe			city)
lon	ding th: : Afte	tior	1 XNatural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	М		k? Yes 2 🗍	No				
Division	ol or Attanding after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	286. Place of Inju	ry - At hon	ne, farm, str	eet, factory	, office			28f. Location (Street and	Number or Ru	ural Route Number,
Ö	s afte	Certification:	4 Homicide	building, etc	:. (Specify)						City or To	wn, State)		
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer		29a. Certifier 1 X Certifying Ph	ysician: To the best oniner: On the basis of	of my know	ledge, deat	h occurred :	at the tim	ne, date an	d place,	and due to the	cause(s) a	nd manner as	s stated.
	To the H within 24 To the F complete	Medical	one)	and manner sta	ted.	JII GII G OI III								
	with To	2	29b. Signature and title of certifier				290	License	number	71	~	29d. Date	signed (Mont	n, Day, Year)
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H	ha		30. Name and address of person who	completed cause of de	eath (Item : ر	23a) (Ťype,	Print)	-01	1311	5	SANI	シード)	212 6
	· ·	10	31. Date filed (Month, Day, Year)	32. Raistra	ar's Signatu	ITO .) اباد	C ;	500	1211	CESVII	LE	MD	4108.
	Sta Registr				sis signan	H.	basel							
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PD				State of	f_Marvlan	d / Depa	adment of		Mental Hyd				
			1 - For Unpend Item 2. Registrar	3ă,27,2	8a≃f pe	Cei	tificate of	Death	Re	g. No.	2005	032	221
	Physici	an	1. Decedent's Name (First, Middle, Las	")					2. Date of Deat Month	Day	2005 ^{ear}	3. Time of	
	/Medic	al	Shanna Carole 4a. Facility Name (If not institution, give	Sm street and num	ith		4h City Town	or Location of De	January	· ·	2005 County of Death	2300	Р м
	Examin	er	306 New York Aven		1001)		Salisbu		3 4 (1)		.comico		
	Funeral		Social Security Number 6. Se		7. Age (In yrs.		If Under 1 Yea Months Days		Hrs. 8. Date of Birth (Month, Day,	Year)	9. Birth	place (State o	r Foreign
	Director		216-29-5714 Usual Residence of Decedent	_M 2 X)F	27	Yrs.			September	15,	1977 Mis	sissip	pi
	yland sow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside Ci	ty Limits
	e Mar ta-f st	ctor	Maryland Wicomio	co	Sal	isbury						1X Yes	2 🗆 No
	with th	Director	10e. Street and Number				10f. Zip Code		1	0g. Citiz	zen of What Cou	intry?	
	eath v	erai	306 New York Avenu		edent Ever in U.	S 13 1	21801	Hispanic Origin?	(Specify Yes or No-	US.	A 4. Race - Amer	ican Indian	
ယ	after d or Item niner	Funerai	1 Never Married 2 Married	Armed Fo 1 ☐ Yes	rces? 2 ∵ ∏No				(Specify Yes or No- lerto Rican, etc.)		Black, White		
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "natural; or Iteme 23s or 28s-f show eumatic event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	ates:		1⊡Yes 2XXN	Specify:			Specify:	White	9
15-	within 72 t ene. then "natu	Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most of t	working	16b. Kir	nd of Business/Ir	ndustry	
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<u>ya</u>	should be ind Mental s marked o umatic eve	To I	Rhett		Dick			Kare				annon	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	H	19a. Informant's Name/Relationship (7		. \				Rural Route Number	0000	4 CH 18	ESCAT.	Y
	is 1 and 2 if Health item 27 other tre		20a. Method of Disposition	(mother	20b. P	Place of Dispo	ew York sition (Name of matory or other p	Avenue,	Salisbury		cation - City or T	21801 own, State	_
altimore,	Pages nent of ant: If it		1 ☐ Burial 2 💆 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		State				ary 25,200)5	Salisbu	rv. Mai	cvland
Balt	permit. Pages Department of I importent: If ite any niury or o		1. Sunature of Funeral Service Licens	s ee		2	Name and Add	ress of Facility Funeral	Home Prof	ess	ional A	ssociat	ion
_	20259		23a. Part1. Enter the disease, or comp	non	CFSP) [01 Snow	Hill Ro	ad, Salish	ury		and 21	1804
			shock, or heart failure. List only of Immediate Cause (Final	one cause on e	ach line.			ing, such as card	diac or respiratory arm	est,		Approximat Interval Bet Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	a	tic Inte		lon						
	Examiner		Sequentially list conditions	b	,								
	sit ad	Examiner	Sequentially list conditions, if any, leading to limit additionate cause. Enter Underlying Cause (Disease or injury	Dua to I	or as a conseq	mence of):							
	axecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):							
760,	or Attending Physicien: The law requires that the death certificate be executed ther death. Jirector: After this certificate has been signed by the attending physicien and Director: After this certificate as been signed by the funeral director, page 2 should be detached for use as the buriar-transit in by the funeral director, page 2 should be detached for use as the buriar-transit.	cai		d									
89	artifica ing ph e as th	Med	IF FEMALE:										
O. Box	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	come of pregna pirth 2 Feta	al death 3	Ectopic pregnar	су		2	3d. Date of deliving Month	•	Year
o.	the de	Physician/Med	1	9☐ Unkn	ant at time of down	ieatii 5	Other (specify)						
ώ.	res that the de signed by the a be detached f	by Pi	Part II. Other significant conditions co	ontributing to d	eath but not res	sulting in the u	inderlying cause (given in Part I.	23e. Did tol	oacco u	se contribute to	the cause of d	leath?
ord	w require been signatured should b	ted							- 1 □ Ye	es 2[No 3□Pro	babiy 4.√(Jnknown
Records,	has be	Completed							24a. Was a autops	y	24b. Were aut	opsy findings ompletion of c	available ause of
a	ilcien: The certificate rector, pag		Of Management and the medical							2 🗆 No	1 Yes	2 No	
<u>=</u>	Physicien: The this certificate had director, page	o Be	25. Was case referred to medical examiner? NX Yes 2 □ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA		Death <i>(Check only on</i> g Home 5 ☐ Reside		Other (Spec	(fv) At S	cene
0	ng Phys ter this neral di	T :uc	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date		28b. Time o		ury at	28d. Describe ho			unk	
Sio	ttendideath.	catio	2 Accident investigation 3 Suicide 6 XCould not be	1-21-	05	10:50	1	Yes 2X No	20/ 1 1/ 12				
Division of Vital	i or Al after o Direc I in by	Certification;	4 Homicide	buildi	_	-	reet, factory, offic	9	28f. Location (St City or Town Salisbur			York	Äve.
_	To the Hospitei or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysicien: To the	d at re	owiedge, deat	h occurred at the	time, date and pl	ace, and due to the c	ause(s)	and manner as	stated.	
	the Holin 24 the Fu	Medical	опе)	and man	asis of examina	ation and/or in			ccurred at the time, d				
,	with To	2	29b. Signature and title of certifier	l			29c. Lice	nse number MF	Į.		e signed <i>(Month</i>		
1			30. Name and address of person who		of death (Iter	m 23a) /Tun-		L I • Li •	J	anuč	ary 22,	2003	
			Co. Ivalie and address of person who	A RTON	1911) III.BEL IO C.			eet, Bal	ltimore, M	ary.	Land 212	201	
	Sta		31. Date filed (Month, Day, Year)		legistrar's Signa				- Control of the Cont				
	Regist	rar	FEB 0 2 :	2005	Alsters.	M. A	Coale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 13, 2005 Charles D. Talley 11:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Arch 5, 1923 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Taylor, SC 250-26-3205 81 Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28e-f show Extrates cast be notified at District of Columbia Washington 14 Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 219 Anacostia Avenue, NE United States by Funerai 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 ⊠Yes 2 ⊡ No within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 years Civil Servant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked other Charley Talley Ola Priestly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Anacostia Ave., NE Washington, DC 20019 Mamie Talley - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Donation 5 ☐ Other (Specify) Jan. 19, 2005 Brentwood, MD Ft. Lincoln Cemetry 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Six ature of Funeral Service Lice so 4001 Benning Road, NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cadse (Final disease or condition Physician Aspiration Pneumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopathy
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examine physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Congestive Heart Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical <u>Dementia</u> as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No detached 9∏ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 20 No certificate 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐XNo 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60619 05 LE, CONNIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, MD 20910 Connie Le 32. Registrar's Signature 31. Date filed (Menth Day Year) State Registrar

			State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2005 03223	
	Physicia	an	1. Decedent's Name (First, Middle, Last) Donald G. Trado 2. Date of Death Month Day Year January 26 2005 0005 A 3. Time of Death January 26 2005	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death	-
	Funeral Director		5. Social Security Number 125–26–7659 7. Age (In yrs. last birthday) Tyrs. 7. Age (In yrs. last birthday) Tyrs. 1	7
	Maryland s-f show	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll County Westminster 10d. Inside City Limits	
	with the	I Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 Baldwin Park Drive 21157 United States	
920	a within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23e or 28e-f show the Modell Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 No 1952 No 1952 No 1952 No 1959 1 Yes, Give Year or Dates: 1 Yes, Specify 1959 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes Specify: White	
21215-0036	within ane. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) U.S. Dept. of Veterans Affairs	
	ld be filed ental Hygis ked other ic event. II	Be	17. Father's Name (First, Middle, Last) Gilbert George Trado 18. Mother's Name (First, Middle, Maiden Surname) Ann Mullin	
Maryland	2 shou and M is mar sumet	To.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	-
	es 1 and of Health fitem 27		20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location - City or Town, State	_
altimore,	t. Pag rtment rtent: I rjury o		Smithsburg Crematorium 2005 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skiles Funeral Home	
B	permi Depa Impo eny ii		136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate	-
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Mutualitie Calan Cause) A 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
ł	Examiner		Due to (or as a consequence of):	
30,	death certificate be executed e attending physician and of for use as the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	
68760,	tificate b og physic as the b	ledical	d.	
O. Box		Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
rds, P.	The law requires that the tee by the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown	
al Records,	(G) —	Completed	24a. Was an autopsy performed? 1 Yes No 1 Yes 2 No 1 Yes 2 No	
f Vital	ysicien iis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	
ion of	ding h. After fune		27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Wor	
Division	spitel or Attendl ours after death. verel Director: A filled in by the fu	Certification	3 Suicide 4 Homicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	H H H	edical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)	
,	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Addeton Loss Poole Road Westmin Her MD 2157	_
	Sta		31. Date filed (Month, Day, Year) FEB 0 2 2005 32. Registrar's Signature FEB 0 2 2005	_
	Regist	ai	LED A COULD DESCRIBE AS DESCRIBE	

DHMH 17 Rev 1/2001

Registrar

			For State Registrer	State of Maryland		rtment of Health a		giene	5 03225
			Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	3. Time of Death
	Physici /Medic		ESTELLE IDAMAE THOM	IAS			JANUAR	Y 17,	2005 8:48 P M
	Examin		4a. Facility Name (If not institution, give st. 5400 LIVINGSTON TER		:02	4b. City, Town, or Location of OXON HILL			E GEORGES
	Funeral Director		J. 000.	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Bir Man. MAY 18	th y, Υθας) 1948	Birthplace (State or Foreign MARYLAND
]	ow II		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Loc	ation			10d. Inside City Limits
	death with the maryland ms 23a or 28a-f ehow Firstel Le Doullied al	to	MARYLAND PRINCE GEO	RGES OXON	HILL				1 ☐ Yes 21 No
1	or 288	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of W	/hat Country?
1	23a c	ralD	5400 LIVINGSTON TER	RACE, APT. #2	202	20745		UNITED	STATES
	ltams ltams	Funeral	TTT THAT DIGITOR	Was Decedent Ever in U.S Armed Forces?	6. 13. V	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Black	- American Indian, k, White, etc.
3	nours enter tural', or Ita	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No Specify:		Specify:	BLACK
215-0036	be lied within 72 hours effer death with tal Hygiene. Ital Hygiene. d other than "natural", or Itams 23a or event, Ital Medical Exer il refrired to a	ted	15. Decedent's Educa	ation	16a. Deced	ent's Usual Occupation		16b. Kind of Bu	
7	within 72 ene. than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. D	kind of work done during most OO NOT use retired)	3		
7	Hygien Hygien other th	Con	12TH GRADE		ENVIRO	MENTAL SERVIC		<u> </u>	INDUSTRY
<u>a</u>	should be til od Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last) HILLERY JOSEPH THOM	MAS, SR.			's Name (First, Middle A MARIE JU		
Mary	and and aum	2.2	19a. Informant's Name/Relationship (Type		1	Address (Street and Number		-	
	of Health Item 27		GEORGE J. THOMAS, J			LIVINGSTON TER	RACE, #202	•	LLL, MAKYLAND City or Town, State
סַר	Pages nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	metery, crem	JRCH CEMETERY			
		1	*4 ☐ Donation 5 ☐ Other (Specify) 21. per ature of Funer 1 Service + 1 serse					MEMDORG,	TAKILAND
eg B	Departr Departr Importr any inji		LADIA C. THORNION JO	HINSON MO0583	34	Name and Address of Facility ORNION FUNERAL HO 39 LIVINGSION ROA	D, INDIAN HEA		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ente	or the mode of dying, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ŧ	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Bloost	cence	/			1420
ı	Examiner			Due to (or as a consequ	ence of):				301
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Use County that initiated events						
o,	cate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):				
8760	cate be executed physician and the burial-transit	dlcal	d.						
9 X O	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	/Me	IF FEMALE:	ic. If yes, outcome of pregnar	nev			22d Date	e of delivery
ရှိ	atten atten I for u	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)		Mor	•
o i	the d by the ached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
ري ح	res that the de signed by the a be detached f	by Pi	Part II. Other significant conditions cont	ributing to death but not resu	Ilting in the ur	derlying cause given in Part I.	23e. Did 1	obacco use contr	ibute to the cause of death?
ğ	w require been sig should b				<u>-</u>		1	Yes 2 XNo	3 ☐ Probably 4 ☐Unknown
Records,	e law re has be je 2 sho	Completed					24a. Was	psy p	Vere autopsy findings available rior to completion of cause of
		Con					perfo	rmed? d	leath? □ Yes 2□ No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	of Death (Check only		
ō	Phys r this ral dir	- To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ I	ER/Outpatien 28b. Time of	t 3☐ DOA Union 4 ☐ Nui	rsing Home 5 Resi	dence 6 Othe	
on	ttending F death. stor: After the funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes 2 ☐ N		,	
Division of	f or Attence efter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	28f. Location (City or To	Street and Number	er or Rural Route Number,
	tal or s efte al Dir ed in	Cert	4 Tionicae	building, etc. (Specify			City of 10	wn, State)	
	To the Hospital or Attending Physician: within 24 hours stelar death. To the Funcal Director: After this certified completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one) 1 Certifying Physical Certification Physical Certification Physi	er: On the basis of examinat and manner stated.	ion and/or inv	occurred at the time, date and restigation, in my opinion, deat	h occurred at the time,	cause(s) and made date and place, a	nner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed	(Month, Day, Year)
			I Wall bila	ne m		D35206		JANUARY	19,2005
5	83		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type,	29c. License number D35706 Print)	me		
4.	Sta		31. Date filed (Month, Day, Year)	32. Raistrar's Signal	ture	lack :			
	Regist	ar	JAN 2 1 20	UJ produce.	N B				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PERLEY TOYE, JR. JANUARY 18, 2005 5:14 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Director 217-34-0876 67 NOVEMBER 12,1937 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 8502 BRANCHWOOD CIRCLE 20735 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Tes 2 No If Yes, Give Year or Dates Specify: BLACK δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) 10TH GRADE College (1-4or 5+) **FOREMAN** CONSTRUCTION of the state of th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PERLEY D. TOYE, SR. EDNA MAE SMITH TOYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Heelth a ent: if Item 27 is 8502 BRANCHWOOD CIRCLE, CLINTON, MARYLAND 20735 MARY B. TOYE / WIFE 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ö permit. Page Department importent: if Importent: if eny injury or RESURRECTION CEMETERY JAN. 24, 2005 CLINTON, MARYLAND * 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funesal Service Licensee

LYDIA C. THORNION JOHNSON MO0583 22. Name and Address of Facility
THORNION FUNERAL HOME, P.A.
34.39 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eaght line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Ce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Physician/Medical Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown Ď s been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has page 2 autopsy certificate 1 Yes 2 🗆 X 10 director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Depatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 □ Yes 2 □ No filled in by the f 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D002420X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABLELHASAN 31. Date filed (Month, Day, Year) 32. Re State

DHMH 17 Rev 1/2001

Registrar

JAN 2

1 2005

		1 - For State Registrar	State of Mar		artment rtificate			-	giene	05	032	27
Physic /Med		Decedent's Name (First, Middle, Las. Tomas Umana)					2. Date of De Month 01-16-	Day	Year	3. Time of 10:40	Death a M
Exami		4a. Facility Name (If not institution, give	al			er Sp	cation of Death Oring Under 24 Hrs.		Mon	unty of Death		
Funera Director		5. Social Security Number 6. Se 578-74-6267 Usual Residence of Decedent	ix 7. Age (. ΔM 2□F	In yrs. last birthday) 67 Yrs.	Months		Hours Min.	8. Date of Bin (Month, Da 10-16-		9. Birthp Cour E1 Sa	place (State of ntry) LIVador	r Foreigi
h the Maryland or 28e-f show a notified at	Irector	10a. State 10b. County Virginia Fairfax 10e. Street and Number	1	Oc. City, Town or Lo		Code			10g. Citizen	of What Cour	0d. Inside Cit 1 ☐ Yes htry?	·
BAIKIMOFE, IMARYIAING ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show sny higury or other treumatic svent, in Medical Evanticar must be notified at snot follow.	by Funeral Director	3401 Elmwood Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Ues 2 M No If Yes, Give Year or Dates:		2230 Was Decede If Yes, specifi	nt of Hispa y Cuban, I		pecify Yes or No o Rican, etc.) Lvadoran	- 14.	alvador Race - Americ Black, White, ecity: Whi	an Indian, etc.	
Z1Z15-0U36 ed within 72 hours aff ygiene. ier than "natural", or t, the Medical Exami	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 3rd		16a. Deced (Give life.	dent's Usual kind of work DO NOT use	done duri retired)	ng most of wor		Resta	of Business/Inc lurant	dustry	
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Domingo Martine 19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (F	ranciso		a	,	Code)	
BEALTIMOTE, MES pormit. Pages 1 and 2 is Department of Health ar mportient: If them 27 is any injury or other treusing injury or other treusing injury.		Aminta de Umana/wi 20a. Method of Disposition 1 🕱 Burial 2 Cremation 3 🗆 1 4 Donation 5 Other (Specify,	fe Removal from State	Alexa 20b. Place of Dispo cemetery, crer Family C	ndria; sition (Name matory or oth emeter	Vir of erplace) y	ginia, 01-2	Date 23-05	20c. Locati San Sa E1 Sa	on - City or To alvador alvador	wn, State	
Dearnit Depart Import		21. Signature of Funeral Service Licens	Bacon C	C 36/3	447 14	th S	t., N.W	l. Bacon V. Wash.	, D.C.		e, Inc	
/Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any leading to the redate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Lung Can Due to (or as a o	cer with consequence of): ve Heart	Metast Failur	asis e			1631,		Approximate Interval Betw Onset and D	ween
cate be executed physicien and the burial-transit	dicai	resulting in death) Last	Due to (or as a c	consequence of):				3416				
death certifi e attending i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [4□Pregnant at tin 9□Unknown	Fetal death 3	Ectopic pred Other (spec				23d.	Date of delive Month	-	'ear
The law requires that the de tite has been signed by the e bage 2 should be detached to	b	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cau	ise given i	n Part I.		obacco use d	contribute to th	e cause of de abiy 4 ⊟Ui	
VICAL HECOFC sicien: The law requir certificate has been si irector, page 2 should	Completed							24a. Was autop perfo 1 \(\text{Yes} \)		death?	osy findings a npletion of ca 2X No	
ding Phy h. After this funeral d	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 🌠 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury		Other: . Injury at Work?	4 🗌 Nursing H	th (Check only o ome 5 Residence 28d. Describe h	lence 6 🗆		')	
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory,	office		28f. Location (S City or Tox		umber or Rura	Route Numb	per,
To the Hospitel of within 24 hours af To the Funerel D completely filled in	edicai	29a. Certifier 1 X Certifying Phy (Check only one) 1 Medical Exam	sician: To the best of riner: On the basis of ex and manner stated	ramination and/or inv	occurred at restigation, i	the time, my opini	date and place on, death occur	and due to the orred at the time, or	cause(s) and date and place	manner as stoce, and due to	ated. the cause(s)	
To to to to to to to to to to to to to to	×	29b. Signature and title of certifier	AMIM		D	59284	+		011	i 6 / 0	Day, Year)	
9		30. Name and address of person who ce Shahid S. Shamim						len Road , Maryla		0917		
S: Regis	tate trar	JAN 1 9 2005	32. Registrar's	April 1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2, Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Earl Richard Vance January 25 2005 1601 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs Director 278-22-4267 May 26, 1927 Ohio Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 Fawn Wav 21921 United States death 12, Was Decedent Ever in U.S. Armed Forces? World 1 Myes 2 □ No If Yes, Give Year or Dates: War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after begardment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Michael Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Everhard Vance Hazel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl A. Hill/Daughter 1 Fawn Way, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) January 29, 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Peace Cemetery! 1 4 ☐ Donation 5 ☐ Other (Specify) Akron, Ohio 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CARDIO MYOPATHY ENDSTAGE /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE CORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine use as the burial-transit The law requires that the death certificate be executed DIABETES and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending physician d be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 🗆 No 1 Yes 2 **X** No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💥 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of . Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 WEST MAIN Brown ELKTON BARRINGTON mD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2005 Registrar

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H rtificate of L			ene	05 0322	29
	Dhyoisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	Day	3. Time of Dea	ath
	Physici /Media		Alice Bertha WI	SE				Linvery		005 O454 e	2 M
	Examir		4a. Facility Name (If not institution, ga			4b. City, Town, or	Location of Deat	h	4c. County	of Death	
			Washington Count	-		Hagers				ngton	
	Funeral Director		220-18-0887	Sex 7. Ag 1 M 2 🖾 F	91 Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1913	9. Birthplace (State or For Country) Maryland	reign
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	paction				101 1 2 0 1	
	aryla sho	5		ington	1					10d. Inside City Li	
	the N	ect	10e. Street and Number	Lington	Hagerstow						
	With the second	۵	Walnut Towers			10f. Zip Code 2174	.0	10	g. Citizen of W	mat Country?	
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13			Specify Ves or No.	USA 14 Bace	- American Indian,	
10	r Itan	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		k, White, etc.	
3	urs a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	white	
215-0036	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show Ital Exama act must be indiffed at	Completed by Funeral Director	15. Decedent's 8		16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bu	siness/Industry	
21	e e e	pje	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	lite	kind of work done of DO NOT use retired	juring most of woi)	rking			
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nd	d oth	Be (17. Father's Name (First, Middle, Las	*		İ		me (First, Middle, M	aiden Sumame	9)	
ya	Men Men arke	ဥ	Angle Daley, Si				Rache	el Myers			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Heatht and Mental Hygiene. 10 of Heatht and Mental Hygiene. 11 of Heath and Mental Hygiene. 12 of other traumatic event, If a Nardigal Exama an must be inclined at		19a. Informant's Name/Relationship					ıral Route Number,	•		
<u>a</u>	and lealth m 27 her t		Harold E. Wise,	Jr son				lagerstown			
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any Injury or other ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crea				0c. Location - (City or Town, State	
Ë	tant:		`4 □ Donation 5 □ Other (Spec			wn Mem. P		7/05 E	lagerst	own, Marylan	.d
a	Depar Depar Impor any In		21. Signature of Funeral Service Lice		- / 22	2. Name and Addres	ss of Facility M	INNICH FU	NERAL 1	HOME	
	40 = 6 d		2000	10-100	much !	415 E. Wi	lson Blv	d., Hager	stown,	Md. 21740	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	y one cause on each li	the death. Do not ent ne.	er the mode of dying	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death	1
F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. When	monue					10days	,
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						4
		_	Sequentially list conditions,	b. — Buo to (or no	a consequence of):						
	led nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury	Due to (or as	a consequence on.						
	xecu and al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
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687	ncate physis the	Physician/Medical		0.		-					
Вох	death certifica rattending ph d for use as tt	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delivery	
m i	The law requires that the death ite has been signed by the attendage 2 should be detached for un	icia	in the past 12 months?	4☐Pregnant a		Ectopic pregnancy Other (specify)			Mon	,	
P.0	that the de led by the a detached f	hys	9 Unknown	9Ll Unknown							
<u></u>	signed of the det	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contril	bute to the cause of death?	?
ğ	w require been sig should b	ed						1 🗌 Yes	2 □ No 3	3 ☐ Probably 4 ☐ Unkno	own
Records,	law requase been 2 should	Completed						24a. Was an	24b. W	ere autopsy findings availa	able
~	the ha	E o						autopsy perform	ed? de	Vere autopsy findings availa Fior to completion of cause eath? Yes & No	of
	ilclan: The lay certificate has rector, page 2	0	25. Was case referred to medical				26. Place of Dea	th (Check only one		Yes 💹 No	
>	Physician: this certificated director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1°☑ Inpatie	ent 2 ER/Outpatier	nt 3 DOA Othe		ome 5 Residen		r (Specify)	- 1
			27. Manner of Death	28a. Date of Inju	ry 28b. Time of Injury	28c. Injury Work		28d. Describe how			
Ö	Attending r death. ector: Afte by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	, , , , , , , , , , , , , , , , , , , ,		res 2 □ No				
Division	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not determined	a 288. Flace of mi	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre		r or Rural Route Number,	
	italo rs aft al Di led in	Cer							-		
	10sp 4 hou unei aly fill	cal	29a. Certifier 1 Certifying P	hysicien: To the best	of my knowledge, death f examination and/or in	occurred at the tim	e, date and place	, and due to the cau	se(s) and man	ner as stated.	
	To the Hospital of Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	Oney	and manner st	ated.						
	N With	<	29b. Signature and title of certifier	Minh		29c. License		290	1. Date signed	(Month, Day, Year)	
			- manger 9	1/sug!	,		8 365		1-	23-05	
in	1-1		30. Name and address of person who	completed cause of c	eath (Item 23a) (Type,	Print)	1- Has	rstown	Maa	12 /	
1	6-1		31. Date filed (Month, Date (Year) A	DSHHIJ.	308 MUL ar's Signature	N. 21100	e luge	121000 N	1002	-1172	
	Sta Registr	~ 6	JAN 24	2005	as signature	sules					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Helen Marie WOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Jashinaton FAHRNEY-K EEDY 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) North Carolina **Funeral** Days 1 ☐ M 2 🖾 F Hours 84 Yrs. 245-20-5712 1920 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene.
Health and Mental Hygiene.
en 27 is marked other than *natural*, or itema 23a or 23a-f show the reaumatic event, tra Medical Esani an marke confilled at 1 ☐ Yes 2 XNo Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No white Specify. 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis M. Davenport Lena Batchlor ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other training. Joseph A. Gunter - son 627 Picadilly Dr., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 K Removal from State Forest Lawn Cemetery 1/28/05 ⁴ □ Donation 5 □ Other (Specify) Norfolk, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME VINO 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** men 8 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disease OYONAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit trial resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2□No 1 Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pendina after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ů, 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ 0060396

Registrar

State

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MD

gardle.

1126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARID

MUNSHED

32 Registrar's Signature

sual Residence of Decedent Da. State 10b. County Earyland Prince C De. Street and Number 9608 Croom Roa	George's 103 10c. City, Town	If Under 1 Year Months Days or Location Upper I 10f. Zip Code 13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No Decedent's Usual Occupa (Give kind of work done diffe. DO NOT use relired) Bus I Mailing Address (Street a 2910 South Disposition (Name of y. crematory or other place U.M. Church 22. Name and Address 4001 Bent out enter the mode of dying	Clinton If Under 24 Hrs. Hours Min. Marlboro 20772 spanic Origin? (Spen, Mexican, Puerto la Specify: Ition Uring most of working Driver 18. Mother's Name and Number or Flura Dakota A Cem 1/17/ s of Facility St ning Rd., g, such as cardiac of	(First, Middle, Ma Rebell Houte Number, Co Ve., N.E. ate 2005 ewart Fu: N.E. Wa r respiratory arres	g. Citizen of What Cou United 14. Race - Amer Black, White Specify: Am Sb. Kind of Business/I Board of E Priva iden Sumame) cca Swain City or Town, State, Z Wash., D Nottinghameral Home sh., DC 2	e George's place (State or Foreign ary land 10d. Inside City Limits 1 Yes 2 No untry? States mican Indian, refican merican Industry Education ate Tip Code) OC 20018 Town, State mam, MD
Bradford Oaks 1 Social Security Number 196. Sex 17-14-7961A A Sual Residence of Decedent Da. State 10b. County Brand Prince Cook Street and Number 9608 Croom Road 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 61h The Father's Name (First, Middle, Last) John Weems 9a. Informant's Name/Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Disposition 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 2 Cremation 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Disposition 3 Relationship (Type Sadie R. Dixon - Da. Method of Dispositi	Aursing Home 7. Age (In yrs. last birt.) 103 10c. City, Town 10c. City	If Under 1 Year Months Days Tor Location Upper I 10f. Zip Code 13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No Decedent's Usual Occupa (Give kind of work done dilife. DO NOT use retired) Bus I Mailing Address (Street a 2910 South Disposition (Name of yor crematory or other place U.M. Church 22. Name and Address 4001 Bent out enter the mode of dying	Clinton If Under 24 Hrs. Hours Min. Marlboro 20772 spanic Origin? (Spen, Mexican, Puerto la Specify: Ition Uring most of working Driver 18. Mother's Name and Number or Flura Dakota A Cem 1/17/ s of Facility St ning Rd., g, such as cardiac of	Nov. IT, Nov. IT, 10g crity Yes or No- Rican, etc.) (First, Middle, Ma Rebe / Route Number, C ve., N.E tate 2005 ewart Fu: N.E. Wa	Prince 9. Birth 1901 9. Citizen of What Cou United 14. Race - Amer Black, Waite Specify: Am Sb. Kind of Business/l Board of E Priva Liden Sumame) cca Swain City or Town, State, Z Nottingh neral Home sh., DC 2	e George's place (State or Foreign ary land 10d. Inside City Limits 1 Yes 2 No untry? States fican Indian, 2 Gercan merican Industry Education ate 10p Code) 10c 20018 10cm, State 10cm, MD 10c 10c 20019 10c 20019 10c 20019 10c 20019 10c 20019 10c 20019
Social Security Number 7 1 9 6. Sex 17-14-79-61A A sual Residence of Decedent 10b. County 10b. State 10b. County 10b. Street and Number 9608 Croom Road 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6th 7. Father's Name (First, Middle, Last) John Weems 9a. Informant's Name/Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Residue 1 Donation 5 Other (Specify) 11. Signature of Fune al Service License 123a. Part 1. Enter the disease, or compile shock or heart failure. List only on mimediate Dause (Final lisease or condition esulting in death)	7. Age (In yrs. last birt. 103 George's 10c. City, Town 10c.	If Under 1 Year Months Days or Location Upper I 10f. Zip Code 13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No Decedent's Usual Occupa (Give kind of work done diffe. DO NOT use relired) Bus I Mailing Address (Street a 2910 South Disposition (Name of y. crematory or other place U.M. Church 22. Name and Address 4001 Bent out enter the mode of dying	Marlboro 20772 spanic Origin? (Spen, Mexican, Puerto la Specify: attion 18. Mother's Name Dakota A Cem 1/17/ s of Facility St ning Rd., g, such as cardiac of	Nov. IT, Nov. IT, 10g crity Yes or No- Rican, etc.) (First, Middle, Ma Rebe / Route Number, C ve., N.E tate 2005 ewart Fu: N.E. Wa	g. Citizen of What Cou United 14. Race - Amer Black, White Specify: Am Sb. Kind of Business/I Board of E Priva iden Sumame) cca Swain City or Town, State, Z Wash., D Nottinghameral Home sh., DC 2	nplace (State or Foreign unity) and 10d. Inside City Limits 1 Yes 2 No unity? States nican Indian, rican nerican industry Education ate 10p Code) OC 20018 Town, State nam, MD 20019 Approximate Interval Between
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Da. State Da. State Da. State Da. Street and Number 9608 Croom Road Da. Street and Number 9608 Croom Road Da. Marital Status 1 Never Married 2 Married 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) T. Father's Name (First, Middle, Last) John Weems Da. Informant's Name/Relationship (Type Sadie R. Dixon - Da. Method of Disposition 1 Burial 2 Cremation 3 Road Cremation 5 Other (Specify) 11. Signature of Fune al Service License Shock, or heart failure. List only on mmediate Dause (Final lissesses or condition esulting in death)	George's ad 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: cation College (1-4or 5+) Daughter emoval from State 20b. Place of cemeter Myers 20cations that caused the death. Do note cause on each line. Atherosclere	Upper 1 10f. Zip Code 13. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No Decedent's Usual Occupa (Give kind of work done diffe. DO NOT use retired) Bus I Mailing Address (Street a 2910 South Disposition (Name of y. crematory or other place U.M. Church 22. Name and Address 4001 Benn not enter the mode of dying ottic Cardiov	20772 spanic Origin? (Spen, Mexican, Puerto la Specify: ation Uring most of working Driver 18. Mother's Name and Number or Flura Dakota A Cem 1/17/ s of Facility St ning Rd., g, such as cardiac of	(First, Middle, Ma Rebell Houte Number, Co Ve., N.E. ate 2005 ewart Fu: N.E. Wa r respiratory arres	United 14. Race - Americal Black, White Black, White Specify: Am Sb. Kind of Business/I Board of Furival American Sumame) cca Swain City or Town, State, Z Wash., Directings Nottings neral Home Sh., DC 2	1 A Yes 2 No untry? States nican Indian, Prican merican Industry Education ate OC 20018 Town, State nam, MD 20019 Approximate Interval Between
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sequentially list conditions, any, leading to immediate						
ause. Enter Underlying	Due to (or as a consequence of	of):				
Cause (Disease or injury nat initiated events esulting in death) Last	Due to (or as a consequence of	-A-				
		<i>,</i> , , , , , , , , , , , , , , , , , ,				
0						
3b. was decedent pregnant	3c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death	3 Ectopic pregnancy			23d. Date of deli	very
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	5 Other (specify)			Month	Day Year
9 ☐ Unknown art II. Dther significant conditions con	stributing to death but not resulting in	the underlying cause give	on in Part I	23e Did toba	cco use contribute to	the cause of death?
artii. Dinoi signiioant oonanons con	and the death out not resulting in	the underlying cause give	mmraiti.			bably 4 Unknown
· · · · · · · · · · · · · · · · · · ·						topsy findings available
				autopsy performe	prior to c death?	completion of cause of
5. Was case referred to medical			26. Place of Death			2 L No
examiner? 1 ☐ Yes 2 ☐No	lospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Othe				cify)
7. Manner of Death 1 → Natural 5 → Pending		ime of 28c. Injury	at ?			
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Blace of Injune. At home to			20f Location (Stro	at and Number or Pu	ural Pouto Number
4 ☐ Homicide determined	building, etc. (Specily)	im, street, factory, office	(rai moute ivarrioer,
9a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	, death occurred at the tim	ne, date and place, a	and due to the cau	se(s) and manner as	stated.
(Check only 2 Medical Examir one)	ner: On the basis of examination and manner stated.	d/or investigation, in my op	pinion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
9b. Signature and title of certifier						
			D19431		January 14	4, 2005
///						
7	examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined Da. Certifier (Check only one) 1 Certifying Physical Examination	examiner? 1	examiner? 1	examiner? 1	Describe how Desc	Second part Second part

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16, 2005 2:45P January Audrey F. Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital Birthplace (State or Foreign
Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 M 2 F Yrs. 77 Director 226-26-3820 Washington, DC 12, 1927 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f ehow or other traumatic event, the Medical Examiner must be notified at 1 Yes 2X No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 3339 North Leisure World Blvd. #222 Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "natural", or Iten any injury or gthar traumatic avent 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 Property Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ochs Claude R. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10610 John Ayres Drive-Fairfax, Virginia 22032 Glenn Stidham (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 18. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive - Gaithersburg, MD. 2087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Respiratory Failure Days /Medical Due to (or as a consequence of): Examiner Days Pneumonia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No õ Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 | No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 ☐ Yes ZX No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Alter Attanding 1 X Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To tha 29b. Signardre ar 29d. Date signed (Month, Day, Year) 2005 cause of death (Item 23a) (Type, Print) S RE EARI 2401 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

		•	For State Registrar	State of Ma	ryland		artmen rtificati			and M	lental Hy	/gien		05	032	233
	Dhysisi	20	Decedent's Name (First, Middle, Last)								2. Date of D Month	eath D:	av	Year	3. Time of	Death
	Physici /Medio		Flora Evangeline	Arrende1	Wall	ker					Januar	y 16	, 20	005	10:00	P M
}	Examin	er	4a. Facility Name (If not institution, give st		. 1				Location of	of Death				y of Death		
			Washington Advent 5. Social Security Number 6. Sex			e himbodous	Tako:		ark If Under	24 Hrs	9 Date of B	I.	lont	gomer		
	Funeral Director			м 2XDF / Age	(In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, E Apr. I	av. Yea 5	922	Nor	olace (State o otry) th Car	r <i>Foreign</i> olina
	ס		Usual Residence of Decedent													
	arylar show	_	10a. State 10b. County			Town or Lo								1	0d. Inside Cit	
	8a-f	cto	D.C. N/A		Was	shing									1 X Yes	2 140
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23e or 28a-f show important: If Item 27 is marked other then "natural", or Itema 23e or 28a-f show any injury or other traumatic event, I'm Medical Exatt and could be notified at ance.	Funeral Director	10e. Street and Number 735 Emerson Stree	t, N.E.			10f. Zip	017				_		Whal Cour	·	
	ma 2	nera	11. Marital Status	2. Was Decedent E	ver in U.S.	13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or N	lo-		ce - Americ		
9	or Ite	Ē	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	lo	1	1 ⊡ Yes		Specify:	i, rueno	Rican, etc.)			ack, White, ity: B1a	-	
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5	"nat	lete	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	rk done a	luring mos	t of work	ing	16b.	Kind of E	Business/In	dustry	
212	withir ene.	g L	Elementary/Secondary (0-12)	College (1-4or 5	+)	Cle:	_	30 7011100,	,			Go	veri	nment		
9	Hyginal Hygina	0	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middl					
Maryland	Aental Aental rked tic ev	To B	Theotric Arrende	1, Sr.					C1y	de P	erry					
ary	and h	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rur	A Route Num	ber, City	or Town	n, State, Zip	Code)	
Σ,	and 2 ealth n 27		Greer M. Thornton	/ Daughte					ad, H	-	sville	-		0783		
ore	1 2 2 2 V		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cen	ce of Dispo netery, crei	natory or o	ther place			Date	20c. 1	ocation	- City or To	own, Slate	
Ë	ment tant: jury		* 4 □ Donation 5 □ Other (Specify)		Mt.	Oliv				1/22	·	Was	hing	gton,	D.C.	
Baltimore	Depar Impor any in		21. Signature of Funeral Service License	ens a ser		Mo	2. Name and CGUIT	e Fu	s of Facilit neral ia Av	Ser	vice , N.W.	Wa	chir	acton	200	12
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate ause. Enter Underlying	Due to (or as a	e. TR a conseque	Annoe of):	0N	F	NE1	UA)	(CN)	M A			Approximate Interval Betto Onset and I	ween
68760,	certificate be executed uting physician and use as the burial-transit	edical Examiner	Cause (Disease or infury that initiated events resulting in death) Last	Due to (or as a	a conseque	ince of):										
.O. Box	death e atter	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Ne- 9 Unknown	c. If yes, oulcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3[⊒Ectopic pr ⊒ Other (sp							ate of delive	•	Year
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S	law rec as bee 2 shot	olete	Strate		0		~				24a. Wa		246.	. Were auto	psy findings	available
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Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical	may	N GIV		-		26. Place	of Deatl	Check only		•			
of V	w 10	Tof	examiner? 1 ☐ Yes 2 ☐ No H	ospital: 1 Empatie	nt 2 E	R/Outpatie	nl 3 🗆 DC	OA Othe	9r: 4 □ Nu	ırsing Ho	me 5 Re	sidence	6 □Ot	her (Specif	y)	
0 0	fter	iio	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time o Injury		8c. Injury Work			28d. Describe	how in	ury occu	irred		
sio	Attending r death. ector: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗌							
Division	after d Direct	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - Al horr :. (Specify)	ne, farm, st	reet, factor	y, office			28f. Location City or T			iber or Rura	il Route Num	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Physics (Chack only one) 2 Medical Examination		examination)
	To the Withir To the Comp	Me	29b. Signature and title of certifier				290	c. License	number			29d. D	ate sign	ed (Month,	Day, Year)	
	1		DRW Middle	NOO				05	38	31			110	e/0:	5	
	4		30. Name and address of person who co	mpleted cause of d	eath (Item 2	23а) (Туре,	Print) (CASH	MNO	CHOR	Svot F.	STEN	V 6	JUSP V	MC	
			ROBIND, Anderson,	M.D.	7600	CA	RRO	u)	ANEI	NUE	TAKO	Mex	DA	PK M	\$ 200	212
		ate	31. Date filed (Month, Day, Year)	39. Registra	ar's Signatu	Ire Am	W.						•			
	Regist	rar	JAN I 3 ZUU:	11/18/14	15	15710	-									

		1	1- State of Maryland Registrer	-	rtment of He tificate of D		ental Hygie	2005	03234
	Physici	an	Decedent's Name (First, Middle, Last)	W.T.	LONG		2. Date of Death Month	Day Yea	
	/Medic Examin		VIRGINIA DOYLE 4a. Facility Name (If not institution, give street and number)	WE:	LLONS 4b. City, Town, or	Location of Death	January	18, 200 4c. County of De	
	LAdiiii	E1	Calvert Memorial Hospital		Prince	Frederic	k	Cal	vert
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. E	Birthplace (State or Foreign Country)
	Director		217–16–4812 81 Usual Residence of Decedent	113.			Jan 29,	1923 M	aryland
	laryland show		10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	Be-f s	Director	Maryland Anne Arundel		Deale				1 ☐ Yes 2 No
	with the		10e. Street and Number		10f. Zip Code		10g.	. Citizen of What	Country?
	death ms 23	Funeral	5918 R, Deale Churchton Road 11. Marital Status 12. Was Decedent Ever in U.S	. 13. V	20751 Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	U.S.A. 14. Race - A	merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other treumatic event, Ire Modical Exartified: aust be notified at ODGs.	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	li li	Yes, specify Cubar ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Specify:	hite, etc. vhite
2	72 hou	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	tion uring most of working	161	b. Kind of Busine	
21215-0036	vithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	`life. L	OO NOT use retired)	oning most of working		orm hom	
	filed v Hygie other t		10 17. Father's Name (First, Middle, Last)	HOITE	emaker	18. Mother's Name	(First, Middle, Mai	own hom	e
lan	Mental Arked o	To Be	unknown			Alice A	nna Bai	rthalow	
Maryland	2 should I and Meni Is marke eumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a.	nd Number or Rurai	Route Number, C	ity or Town, State	e, Zip Code)
	1 and 2 Health tem 27 I	3	Levi Thomas Wellons, Jr., spouse 20a. Method of Disposition 20b. Pla		8 R. Deal			Deale, Mo. Location - City	
100	nt of h		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, cren	natory`or other place))			
aitimore,	artme ortent injury	- 1	` 4 □Donation 5 □Other (Specify) Rose 21. Signature of Funeral Service Licensee		Cemetery Name and Address		5-05 Se	edley, V	VA
ã	Depared Important any in		* Williams Thom	F	Rausch Fur	neral Home	e, P.A.,	Owings,	MD 20736
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		rhy thn	214.			5 mixures
	/Medical Examiner		Due to (or as a consequence of the process of the p		' Caral	m11000011b	ma alice	0000	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		<u>c</u> <u>w/c()</u>	00030010	0) 093	. O.2 C	
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events c.						
60,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a conseque	ence of):					
68760,		edical	d						
Box	ndir use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of the past 12 months?		Ectopic pregnancy			23d. Date of o	delivery Day Year
P.O. E	es that the death igned by the atte be detached for	yslci	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown 9 ☐ Unknown	ath 5□	Other (specify)			1401101	ouy roal
	s that ned by e deta	by Ph	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ords	w require: been sig should b	ed b	End Stage Chronic Obstructi	ve Pu	Imonary	Distose	1 1 Tes	2 □ No 3 □	Probably 4 Unknown
Records,	has be	Completed	Congestive Heart Failure, 1	Atrial	fibril	lation,	24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
a H	icate l		Coronary Artery disease Hy	pente,	nsive Hea			d? death	
Vital	Physicien: r this certificated free forth	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA Othe	26. Place of Death	(Check only one) ne 5 ☐ Residence	a 6 DOthor /S	pagiful
ı of	ding Physicien: The I h. After this certificate ha funeral director, page		27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury Work		8d. Describe how i		obcny)
sior	or Attending uter death. Director: Afte	catlo	2 Accident investigation		M 1 7	'es 2□No			
Division	after d	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Exeminer: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. lue to the cause(s)
	To ti Vithi To ti comp	Ž	29b. Signature anotifie of certifier		29c. License	number		Date signed (Mo	
,			tyu c. surona		1) 50	0653			× 00)
1	0		30. Name and address of person who completed cause of death (Item 5851 - Deale Churchte	23a) (Type,	Print) GYA, Road + #	16. T	ournn Deale		20751
	Sta		31. Date filed (Month, Day, Year) 32. Registry's Signatu		1				
	Regist	rar	JAN & 4 LUUS P Classes	10	HOBELLES				

	4		For Amend//23a onh	State of Maryland				•		o o c	000	7 /7 /**
			1 - State Registrar per phy. 1/28/	O5 AAOO HEALIH B	EPT Cei	tificate of L	Death		eg. No.	000	UJa	235
П	Physicia	an	1. Decedent's Name (First, Middle, Last) Anna Winn					2. Date of Deat Month	Day	Year	3. Time of	
j.	/Medic	al	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	January		2005 ounty of Death	5:20	РМ
	Examin	er	Chesapeake Hospice			Linthicu				e Arunde	- 1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Birth (Month, Day,		9. Birthp	lace (State o	or Foreign
	Director		Usual Residence of Decedent	M 2KIF 83	Yrs.			(Month, Day, 04/24/1	921	Rhode	e″Isla	nd
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside C	ity Limits
	Ba-f s	Director	Maryland Prince Geo	orges Bo	owie						1 XYes	2□No
	with th		10e. Street and Number			10f. Zip Code		1	-	on of What Coun	itry?	
	ns 23	Funeral	12409 Shelter Lane	2. Was Decedent Ever in U.	S. 13.	20715 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	acify Yes or No-	USA 14	I. Race - Americ	an Indian,	
9	after or Itar	Fun	1 ☐ Never Married 2 【X Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)		Black, White,	etc.	
Maryland 21215-0036	ba filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural; or Itams 23a or 28a-1 show d other than "natural; or Itams 23u or 28a-1 show event, Ita Medical Exand or must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			Specify:			Whit		
5	in 72 "nat	olete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	luring most of work	ing		of Business/Inc ed State	•	
212	d with giene.	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Perso	nnel Cler	k			ral Gove		ıt
ם	ba file tal Hy d othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, i	Maiden S	umame)		
<u> </u>	d Men narke	2	Giuseppe Pichierri	na Drintl	10h Maili	an Address (Chart	Maria Pa	9		Town Chair 7/2	Codel	
<u>ā</u> ≥	id 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (Type Bernard J. Winn/ Hu		1	ng Address (Street a Shelter					Code)	
ē,	s 1 ar if Hea item 3		20a. Method of Disposition	20h. P	lace of Dispo	sition /Name of				ation - City or To	wn, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Evan Instrument be notified at once.		1 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	emoval from State Vet	Maryl terans	matory or other place and Cemetery	01/19	2/2005 C	rown	sville,	MD	
3alt	permit. Departr Importa		21. Signature of Funeral Service License	99	and the same	2. Name and Addres						ie
	0 □ = e o		23a. Part1. Enter the disease, or compli	cations that caused the death		000 Annap				yland 20	J715 Approxima	ta .
			shock, or heart failure. List only on Immediate Cause (Final	Carcinoma of						of the 7	Interval Be	tween
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequ		Lung 110gr	COSTAG LETT	grant No.	Turan.	OL devy	авпа	
	Examiner		Sequentially list conditions			the rectum						
	ad isit	liner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience of):							
	be executad ician and burial-transit	Examin	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):				_	-		
760,	ate be executad nysician and he burial-transit	call		l								
89	death certificate b attending physic d for use as the b	Medi	IF FEMALE:									
Вох	death certifica e attending ph d for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23	d. Date of delive Month		Year
o.	that the deatl ed by the atte detached for	nyslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	adui 5	Other (specify)						
<u>ر</u> ب ت	requires that een signed b nould be deta	by Pl	Part II. Other significant conditions con	stributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to th	ne cause of	death?
ord	w require been sig should b							1 🗆 Y	es 2□	No 3 Prob	ably 4 🔀	Unknown
Records,	law as b	ompleted						24a. Was a autops	sy		psy findings mpletion of c	available cause of
a	Th ate pag	O	25 W					performula 1 Yes	2 💢 No	death? 1 ☐ Yes	2 No	
Vital	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Othe	26. Place of Deat er: 4 Nursing Ho	n (Check only or me 5 ☐ Resid		Other (Specif	v) Hogg	ice
n of		T:uc	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		at	28d. Describe h			, 1103p	100
Sio	Attending r death. ector: After	catle	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	005 1	44	M	10	
Division	after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		Number or Hura	u Houte Nun	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 X Certifying Phys	sician: To the best of my kno	wledge, deal	h occurred at the tim	ne, date and place,	and due to the c	ause(s) a	ind manner as s	tated.	
	in 24 the Fu	edical	(Check only 2 Medical Examil	ner: On the basis of examina and manner stated.	tion and/or in							s)
	To T To T	Σ	29b. Signature and title of certifier	1,000+3	A	29c. License		ŀ		signed (Month,	Day, Year)	
			20 Name and address of parcon who are). Weltz		D2374			01/19	8/2005		
			30. Name and address of person who co				Greenbelt	, Maryl	and	20770		
* 5	Sta		31. Date filed (Month, Day, Year)	32. Reststrar's Signa	ture							
	Regist	rar	JWM TO	2005	137	And						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 15 Whittington 2005 8:30 Leola January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lothian

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year July 3 19 5299 Sands Road Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 95 1909 Maryland Director 212-28-8244 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 TYes 2 No Maryland Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 5299 Sands Road 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: ð 3 ☑ Widowed 4 ☐ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "n any injury or other traumatic event, Ita Meal once. Elementary/Secondary (0-12) College (1-4or 5+) 6th Private Family Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Turner James Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Duff (Daughter) 1215 Whittington Dr. Lothian, Md. 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Moses Cemetery 1/21/05 Drury, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 Zarry H. Reese Mo0483 | Wm. Reese & Sulls Plut Luar West St. Annapolis,

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Stenosis Immediate Cause (Final disease or condition resulting in death) **Physician** Soyears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien ar s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) P.O. 1he 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ rebral vascular accident 1 X Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 Yes 28 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA ၉ 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending death. Director: A 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funerel C Medical 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Magne Burban January 18, 2005 D38563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , West River 134 Owars ville RD Wayne Bierbaum and 31. Date filed (Month, Day, Year)

JAN 18 32. Segistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SARAH AGUSTA WERNER JANUARY 23 2005 8:41 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | NOV 29 191 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 K 214 01 0125 90 Director MARYLAND Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MARYLAND ALLEGANY MT. SAVAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15709 IRON RAIL STREET, NW 21545 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after de il Hygiene. other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ₩idowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt timent of Health and Mental Hitant: If Item 27 is marked oth jury or other traumatic even Be JOHN PRATT 2 DORCAS CRIGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 884 FINZEL ROAD, FROSTBURG, MD 21532 VICKIE BAKER / DAUGHTER 20a. Method of Disposition

1 Aburial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ST. PATRICK'S CEMETERY 1/25/05 MT. SAVAGE, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET FROSTBURG, MD 21532 SOWERS FUNERAL HOME, P.A. James 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endstage **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Records, P.O. 9□ Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2500 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital fo the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one 3 □ DOA Other: 4 Sursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death uneral Director: / ily filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/24/2005 121244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESUS H. TAN, M.D. FROSTBURG PLAZA, FROSTBURG, MD 21532 31. Date filed (Month, Day, Year) FEB 0 3 2005 32. Registrar's Signature State Eller Registrar

05-00300 Phillip Martin Wood
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 05-00300 1- For Unpend Item 23a,27,28a-f per me GB40 2-17-05 tas

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 12. **Phillip 20**05 Martin Wood 15:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5115 Taft Road Camp Springs Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F 44 Yrs. Director UNKOWN Cheverly, Md. May 30, Usual Residence of Decedent

10a. State UNK 10b. County the Maryland unk unk 10c. City, Town or Location 10d. Inside City Limits worle r items 23s or 28e-f ehov ther reset be notified at 1 □Yes 2 No Directo 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 至 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Madical Extendment angle. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 Ó Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Mary Savoy George Robert Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Heatherleigh Pl. White Plains, Md. Brenda Wood / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 21, 2005 Clinton, Md. Resurrection 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic-22. Name and Address of Facility Pope Funeral Homes, P.A. Pike/Forestville, Md. Alexander S. 3538 Mariboro Turas of Olding 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypothermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 → Yes 2 □ No Yes 2□ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
XXYes 2 \sum No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 28d. Describe how injury occurred
subject inadvertently exposed
to cold environmental
temperature and Number or Rural Route Number,
City or Town, State) 5115 Taft Road
Camp Springs, Maryland 28a. Date of Injury
Found th, Day Year) After the 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural Found 3:22 5 Pending death. 1 ☐ Yes 2 No investigation 2X Accident 1-12-05 within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined vehicle 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2005 ge 30. Name and address of person who completed cars of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

State

31. Jan (Ned (Moeth, Day Year)

2. Registrar's Signature

			For State Registrar	State of N	Maryland / De	-	of Health		tal Hygie	2005	03239
	- · · ·		1. Decedent's Name (First, Middle,	Last)			_		Date of Death		3. Time of Death
	Physici: /Medic		Lionel Lee Woo							7, 2005	9:13 P ^M
	Examin	er	4a. Facility Name (If not institution,		or)		own, or Location			4c. County of Dea	
			Holy Cross Hosp: 5. Social Security Number		Age (In yrs. last birth		ver Spri		Date of Birth	Montgome	
	Funeral Director		115-20-0724	1 ⊠ M 2□F	83 Yr	Months	Days Hours	Min. (Month, Day, Ye		thplace (State or Foreign ountry) W York
	D .		Usual Residence of Decedent		40.00.7			, <u>k1</u> P	111 25,	1721 110	
	laryla ehov	'n	Maryland Montgo	nerv	Silver						10d. Inside City Limits 1 X Yes 2 □ No
	28a-1	Funeral Director	10e. Street and Number		DIIVEI	10f. Zip (Code		100	Citizen of What Co	
	3a or		12417 Borges A	7.0		209			iog.	USA	ound y ?
	death	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Decede	ent of Hispanic O fy Cuban, Mexica	rigin? (Specify	Yes or No-	14. Race - Ame	
98	or Ite	y Fu	1 ☐ Never Married 2 Marrie	d 1⊠Yes 2[If Yes, Given	945-WW II	1 ☐ Yes 2			n, etc.)	Black, Whi	white
Ş	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow siest Examinat must be neilified at	ed by	3 Widowed 4 Divorced			ecedent's Usual			100		
5	n na	piet	(Specify only highest	grade completed)	()	Give kind of work ife. DO NOT use	done during mo retired)	st of working		o. Kind of Business	rfare Center
21215-0036	d with	Completed	Elementary/Secondary (0-12)	4 Yrs.	Mech	anical	Engineer	c	34	illace wa.	riare Center
Pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, La	ast)			18. Moth	ner's Name (Fir	rst, Middle, Mai	den Sumame)	
yla	Men Men Marke Marke	ို	William D. Wool						E. Benn		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Merala Hyglene. Important; if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any figury or other traumatic event, the Medical Examinar must be notified at ance.		19a. Informant's Name/Relationshi Stephen Woolsto:							ity or Town, State, MD 20874	Zip Code)
ē,	tem 2		20a. Method of Disposition			isposition (Name crematory or oth	-	Date		Location - City or	Town, State
Baltimore,	Pages ent of nt; If I		14 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		(e)	id Vets.		11/2//2	005 Cr	ownsvill	o MD
aiti	permit. Departm Importa any Inju		21. Signature of Funeral Service Li	censee	filal y Lai		Address of Faci	Hines	-Rinald	i Funera	l Home
<u> </u>	89589		Janoly &	Wil	>						ng,MD 20904
П			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caus nly one cause on each	ed the death. Do no	t enter the mode	of dying, such as	s cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		Myocardia		ction				Days
П	Examiner			Due to (or Multi	as a consequence of ple Organ	: Failure					Days
		Jer	Sequentially list conditions,		as a consequence of						
	ocuted and transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c	Cereb						
60,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or	as a consequence of						
68760,	death certificate be executed e attending physician and kd for use as the burial-transit	Physician/Medical		d							
Box (eath certific attending pl for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor						23d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	2 ☐ Fetal death at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe				Month	Day Year
P.0		hys	9 Unknown	9 Unknown							
	gr gr	þ	Part II. Other significant condition	s contributing to death	n but not resulting in t	he underlying ca	use given in Part	1.			o the cause of death?
Orc	w requir been si should	eted						-		2LIN0 3LP	robably 4 XUnknown
of Vital Records,	Ф <u>г</u> <u>Ф</u>	Completed							24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
tai	iclan: Th certificete rector, pag	e Co	25. Was case referred to medical				OC Place		1 ☐ Yes 2tv		2 X No
Ž	S S S	OB	examiner? 1 ☐ Yes 2 🔀 No	Hospital: Inpa	atient 2 ER/Outp	atient 3 DO/		e of Death Ch lursing Home		e 6 ⊡Other (Spe	ecify)
	ding Ph After thi funeral	n: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of le			lc. Injury at Work?		Describe how i		
sio	Attending r death. ector: After by the fune	catle	2 Accident investigated in Suicide 6 Could no	ation of he		М	1 ☐ Yes 2 ☐				
Division	l or Attendate after deati	Certification:	4 Homicide determin	ed 28e. Place of	Injury - At home, fam etc. (Specify)	n, street, factory,	office		Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	Hospital or 24 hours afte Funeral Directory filled in	ai Ce	29a. Certifier 11 Certifying	Physician: To the be	st of my knowledge.	death occurred a	t the time, date a	nd place, and	due to the caus	e(s) and manner a	s stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical E	xaminer: On the basis	s of examination and/	or investigation.	in my opinion, de	ath occurred a	t the time, date	and place, and due	o to the cause(s)
	vithin 2 To the complet	ž	29b Signature and title of certifier		. 2	29c.	License number		29d.	Date signed (Mont	
•	15		R A	·Nawe	7	7	509	8+	1	-18-0	
	•		30 Name and address of person was AHMED NAW	and manner Nawa ho completed cause of AT Po 6 2005	of death (Item 23a) (T	ype, Print)	aithe	rsbu	rar	no 20	2883
	Sta	ite_	31. Date filed (Month, Day, Year)	32. regi	strar's Signatyre	1 Maria	10001.10		0		
	Registi		JAN 20	2005	we to	gover					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 22 **Physician** 2005 Donald Lee Weaver, Sr. 0045 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** E1kton Ceci1 Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**¼**M 2□F Days Hours Min Yrs. Director 70 22, 1934 216-30-7517 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 Is marked other than "netural", or Items 23a or 28e-f ahow traumatic event, It's Madical Examinational be matified at 1 ☐ Yes 2 🛣 No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Brewster Bridge Road 21921 United States Funera 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No
1 Fes. Give
Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grover Harry Weaver Violet Virginia Crampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra Donna L. Hicks/Daughter 161 Brewster Bridge Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of Cherry Hill Cherry Hill Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State January 25, 1 XBurial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 2005 Cherry Hill, Maryland All Name and Address of Facility.
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician PANCREATITIS NECROTISING disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): Examiner ISCHEMI A WHENEPED MESENTERIC Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury burial-transit MYOCARDIAR SWARLTION 27 DAYS that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, The law requires that the death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Acute. REMAR FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed ALKUMONIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CONGESTINE HEAVET FAILURE 1 ☐ Yes 2 ☒ No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification; Injury at Work? Atter 1 XNatural 5 Pending after death. | Director: At 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours atter To the Funeral Direct cal 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO0 (8392 January 22nd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOINL MOSILIAL DR. CANDERP GAUTAM ELKTON, MD 21921 31. Date filed (Month, Day Year 2. Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

			For State Registrer		State of Ma	ıryland		irtment of F tificate of		Mental	Hygiene Reg. No.	2000	03261
ı	Physici /Medic		1. Decedent's Name (First		Weller	^				2. Date of Month	Day	2 2005	3. Time of Death 0625 A M
	Examin Funeral Director		4a. Facility Name (If not in Washington (5. Social Security Number 215-42-3106	County F	Hospital		ast birthday) 51 Yrs.		er Location of Deat ers town If Under 24 Hrs Hours Min.	8 Date of	of Birth	County of Death Vashing to 9. Births Cour MD	DID blace (State or Foreign ntry)
	D	tor	Usual Residence of Deceded 10a. State 10b.	dent County ashingto	on	10c. City	Town or Lo			July			l Od. Inside City Limits 1 ☐ Yes 2 XNo
	within 72 hours after deeth with the Maryland ene. than "netural", or items 23a or 28a-f show he Madical Examinar mail be notified at	Funeral Director	10e. Street and Number 12922 Saler 11. Marital Status	m Avenue	2. Was Decedent F			10f. Zip Code 21740		Specify Yes o	USA	izen of What Cour	
-0036	hours after of tural', or Item al Examiner	þ	1 Never Married 2		Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	lo	1	Yes, specify Cub Yes 2 No		to Rican, etc		Black, White, Specify: Whj ind of Business/In	etc. Lte
Maryland 21215-0036	led within 72 tygiene. her then "ne nt, the wedic	Completed	(Specify only Elementary/Secondary 12	y highest grade (0-12)	completed) College (1-4or 5	+)	(Give	kind of work done OO NOT use retire	during most of wo		Ow	m Home	dustry
aryland	should be fi and Mental H s marked of umatic ever	To Be	17. Father's Name (First, IIII) Roger E. We	eller	e, Print)		19b. Mailin	g Address (Street	18. Mother's Na Kittie and Number or R	I. Yo	unker		Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Marcical Examiner must be notified at ODGs.		John E. Well 20a. Method of Disposition 1 X Burial 2 Crem 1 4 Donation 5 C 21. Signature of Funeral S	n mation 3 □Re Other <i>(Specify)</i>	moval from State		ace of Dispo emetery, cren enebric	sition (Name of natory or other pla age Cemet . Name and Addre	tery 01/2	27/05 14	Hand 41 Wes	cock MD t Main S	
	Physician /Medical Examiner	ier	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate	a.	ations that caused a caused a cause on each line. At ev Due to (or as a	o SC a consequ	Do not enter level	er the mode of dyi		c or respirato	ory arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a	a consequ	ence of):						
P.O. Box	the death certi y the attending sched for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iani	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		_	23d. Date of delive Month	ery Day Year
Records, P	w requires that the de been signed by the a should be detached f	eted by Ph	Part II. Other significant of	conditions cont	ributing to death bu	ut not resu	lting in the ur	nderlying cause gr	ven in Part I.		1 □ Yes 2 {	□No 3 Prob	
Vital Rec	lan: The law rtificate has l ctor, page 2 s	Be Completed	25. Was case referred to	medical					26. Place of De	1 🗆 Y		prior to condeath?	psy findings available mpletion of cause of
Division of V	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To E	2 Accident	Pending investigation Could not be determined	28a. Date of Injui (Month, Day	Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo M 1	ry at	28d. Desc	ribe how injur	d Number or Rura	
۵	e Hospital or Attending I 24 hours efter death. 9 Funeral Director: After etely filled in by the funer	Medical Cert	29a. Certifier 1 🗆 C	Certifying Physi Medicel Examin	building, etc icien: To the best of er: On the basis of and manner sta	of my knov	vledge, death	occurred at the ti	ime, date and place	e, and due to	the cause(s)	and manner as s	tated. o the cause(s)
ì	To the Vithin 2 To the Complet	Me	29b. Signature and title of	Will	ent D	B. F	Acor	29c. Licens	2011			te signed (Month,	
	Sta		30. Name and address of the mas 3. 31. Date filed (Month, Da FEB 0	y, Year)	npleted cause of d	.O. F	ACOD !	951 E - A	ntietam	St. H	agerst	Lown, MJ	2, 2005
DH	Regist	Α	I LD 0	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	fill are	o Li	Ross	E.					

			1 - For State Registrar	State of Maryland			t of H	ealth a		ental Hy		-200)5	0.3	242
	Physici /Medio		Decedent's Name (First, Middle, L Leonora	Rodriguez			ano			2. Date of Do Month Jan.	, 2 ^{Da}		'ear		5p M
	Examir Funeral Director				birthday) Yrs.	Si	lve	r Sp	ring	8. Date of Bi (Month, D. 9 / 1 4			gomes gomes Birthplace Country) Colo		or Foreign
1	D	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince	e George's Ad	own or Lo						7.13	30	10d. I	nside C	City Limits
	th with th	al Dire	10e. Street and Number 1828 Metzero	t Rd. #501		10f. Zip	Code 2078	3			-	tizen of Wh Colom	at Country? bia		
9036	be filed within 72 hours after death with the Maryland ntal Hygliene. Id other than "natural", or Items 23a or 28a-f show event. The Medical Examinat must be rediffied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates:						cify Yes or Natican, etc.)	-		American Ir White, etc. Whit		
21215-0036	- 2	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)		dent's Usua kind of wor DO NOT us			of workin	ng		ind of Busin	ome	у	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be (17. Father's Name (First, Middle, Las Gabriel Rodr:	•						(First, Middle 20.		,			
	1 and 2 Health a em 27 is		19a. Informant's Name/Relationship Enrique M. Rod 20a. Method of Disposition 1 ☆Burial 2 □ Cremation 3	driguez/Son	182 of Dispo	28 Me	tze	rott	. Rd	#501	Ade	elphi ocation · Ci	, Md	. 2 State	
Baltimore,	permit. Pages 1 a Department of Hea Important; if item any injury or othe		4 □ Donation, 5 □ Other (Spec	"D Gal	-	E Hea PHTLI 2211				/2005 L FUN Lvd.S					
	Enysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Colon per	for a	er the mode	e of dying						App Inte Ons	roxima rval Be set and	te
8760,	Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last	b. Colon obs Due to (or as a consequent c. Due to (or as a consequent	truc	ctior	1			OKNIC				24	days
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		Ectopic pro		30.0		7.70		23d. Date o		770°	Year
ds, P	juires that n signed b ild be deta	þ	Part II. Other significant conditions	contributing to death but not resulting	g in the u	nderlying ca	ause give	n in Part I.			tobacco Yes 2		ute to the ca		
Vital Records,	The ate h page	Completed								24a. Was auto perfe 1 \(\text{Yes} \)		prio	re autopsy libr to completeth? Yes 2	ion of a	
of	ding Phyalcian: Th h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1½ Yes 2 □ No 27. Manner of Death 1 ☒ Natural 5 □ Pending investigati	28a. Date of Injury (Month, Day Year)	Outpatier D. Time of Injury		3c. Injury Work	r: 4□Nui	rsing Hon	(Check only ne 5 Res 8d. Describe	dence				
Division	il or Attending after death. Director: After d in by the fune	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Injury At home	, farm, str	eet, factory				8f. Location (City or To			or Rural Rou	ite Nun	ıber,
	To the Hospital within 24 hours a To the Funerel C completely filled	edicai C	29a. Certifier (Check only one) 1 X Certifying F	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	dge, deati and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s date and) and mann d place, and	er as stated. I due to the	cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Touch	u A		D20					te signed (i	Month, Day, 2005	Year)	
_			30. Name and address of person wh Ira Tannebau	m MD 1500 Fc	res	t Gle		d. S	Silv	er Sp	rinc	,Md	20910)	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 19	32. Segistrar's Signature	A	sele!									

			State of Maryland / Department of Health and M 1 - State		2005 0221.2
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	
ı	Physicia		Walter Zadoretzky	Month January	Day Year 13 2005 3:13 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
		•	Anne Arundel Medical Center Annapolis		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		051-18-4/3/ 81	May 31,	1923 New York
	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary f sho	to	Maryland Anne Arundel Annapolis		1 ⊡Yes 2√⊡ No
	r 28a	Directo	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Country?
	23a o		1534 Gordon Cove Road 21403		United States
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel; or Itams 23a or 28a-f show ant, the Medical Examinat must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No 2 □ No Specify: 1 □ Yes 2 □ No Specify: 1		Specify:
21215-0036	hour tural	d be	3 ₩ Widowed 4 □ Divorced Year or Dates: 1943-1946 15. Decedent's Education 16a. Decedent's Usual Occupation		white 16b. Kind of Business/Industry
5	in 72 n "na nedic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	king	,
72	filed with Hygiene. ther that	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 builder		self employed
	a file of he vent,	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, M	Maiden Sumame)
/lar	should ba nd Mental marked c	To E		enchynsk	-
Maryland	2 should ba v and Mental Is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 2.1.2.1 A value of a reason Design		
2			Peter Zadoretzky/ son 3121 Anchorage Drive 20a Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or Town, State
Baltimore,	parmit. Pagas 1 and Department of Haalth Important: If item 27 any injury or othar tonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		
I iii	it. Pa rtmen rtant: njury			14, 2005	Baltimore, MD Tor Funeral Home, Inc.
Ba	parm Depa Impo any i		H 2 At Manager		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	Annapolis MD 21/01 Approximate Interval Betyeen
			shock, or heart failure. List only one cause on each line.	POLLIN	Onset and beath
	Physician /Medical		disease or condition resulting in dealh) a. Due to (or as a consequence f):	3 11-0 19 3	1000/3
	Examiner		Companied to the conditions		
	B ≅	ner	Sequentially list conditions, ft any, leading to immediate cause. Enter Underlying		
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of);		
8760,	cate be executed obysician and the burial-transit	E	Due to (or as a consequence or).		
387	cate physi s the l	dical	d		
9 x	death certific e attending p ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	death a atter	cia	in the past 12 months? 1 Very 2 No. 4 Pregnant at time of death 5 Other (specify)		Mount Day fadir
o.	that the de ed by the detached	hys	9 Unknown		
۵,	ras tha igned be det	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the cause of death?
ırd	w requiras baen sign should be			1 □ Ye	es 2 A6 3 Probably 4 Unknown
ecords	aw 1s b	Completed		24a, Was a autops	prior to completion of cause of
$\mathbf{\alpha}$	9 4 8	Com		perform	ned? death? 2 No 1 ☐ Yes 2 ☐ No
Vital	ysician: Th is certificate director, pag	Be (evaminer?	ath (Check only on	е)
of \	S S	ပ			ence 6 Other (Specify) ow injury occurred
on c	ing F After unera	ion	27. Manney of Death 28a. Date of Injury 28b. Time of Sec. Injury at Work? 1 Matural 5 Pending (Month, Day Year) N M Injury M M 1 Yes 2 No	28d. Describe III	ow injury occurred
isic	Attending r death. actor: After	icat	3 Suicide 6 Could not be 380 Place of Injury. At home farm street factors office	28f. Location (St	reet and Number or Rural Route Number,
Division	or A after Dirac	Certification;	4 Homicide determined building, etc. (Specify)	City or Town	n, State)
	s Hospital 24 hours a e Funeral i letely filled		29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Diractor: After thi completely filled in by the funeral.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	irred at the time, d	ate and place, and due to the cause(s)
	To the L	Ž	29b. Signature and tyle of pentitier 29c. License number	2	9d. Date signed (Month, Pay, Year)
			May 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7	01/15/2000
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	16	Dan all mil
			31. Date filed (Month, Day, Year) 32. Agistrar's Signature	VE /	1181116/11/11/11/11/11/11/11/11/11/11/11/11
	St. Regist	ate rar	JAN 1 4 2005		

			For State Registrar	State of M	aryland		artmen tificate			nd Me		giene Reg. No.	2005	5 03	244
E	Physici /Medic		1. Decedent's Name (First, Middle, Las Robert	st)	Z	ucki	erm	an		2	Date of Dea Tanua	Day	16 200	1 6	of Death
<i>f</i>	Examin		4a. Facility Name (If not institution, give	street and number)					Location of	Death			County of De	ath	
			Riderwood Villa						pring				ontgom		
	Funeral Director		5. Social Security Number 6. S 111-18-7741 Usual Residence of Decedent	ex 7. Ag XCIM 2□F	ge (In yrs. Ia:	St birthday) Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Day Aug. 29	y, Year) 9, 19		linthplace (Stat Country) ew Yorl	
iore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It item 27 is marked other than "naturel", or Items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exams in must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgom 10e. Street and Number 3160 Gracefiel 11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Expecify only highest grace (Specify only highest grace) 17. Father's Name (First, Middle, Last, William 19a. Informant's Name/Relationship (Sondra Isquith — 20a. Method of Disposition 1 3 Buriai 2 Cremation 3 Description	d Road 12. Was Decedent Armed Forces: 1 Xfes 2 1 Yfes, Give Year or Dates: ducation	Ever in U.S No 1943 – 4 5+)	15a. Deced (Give life.)	r Spr 10f. Zip Nas Deced f Yes, spec 1 Yes dent's Usua kind of wo. DO NOT us Lawye ag Address Grac sition (Namatory or or	209 dent of History Cuba 200 No 200 No coupark done can retired 200 (Street a cefic	spanic Origin, Mexican, Specify: ation during most of He and Number eld Ro	of working 's Name (elen or Rural ead Da	ify Yes or Notican, etc.) (First, Middle, Broff Route Number # 108	nited 16b. Kir Maiden ar, City or Silv 20c. Lor	14. Race - Ar Black, WI Specify: Wind of Busines: Law Sumame) Town, State er Spr. cation - City	Country? Les of American Indian hite, etc. Thite SS/Industry Do, Zip Code) Ling, Minor Town, State	D 20904
Baltimore,	Physician		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Liceral 23a. Part. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each l	Crow	Do not ent	Name ar anzar 170	d Addres		erg Pike	Memori , Roc	al C kvil		Approxim Interval to Onset ar	nate
8760,	death certificate be executed Examine e attending physician and dror use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a)	Uruu sa conseque	ence of):	De	m	intiò	ì					
.O. Box 68	death certifii ie attending p ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3□	Ectopic p					2	23d. Date of o Month	delivery Day	Year
<u>a</u>	Se un equ	by	Part II. Other significant conditions	contributing to death	but not resul	lting in the u	nderlying o	ause give	en in Part I.			obacco u Yes 2[_	to the cause	
Vital Records,		Completed									24a. Was autop perfo 1 Yes		prior t death	autopsy findin to completion o ? es 2 1 No	gs available of cause of
Vita	Physicien: Th This certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	0.00		(Check only o				
o	S S	- T	1 Yes 2 No 27. Manner of Death	1 Inpat		R/Outpatier 28b. Time o		28c. Injun	- Nurs		e 5 🗆 Resid			pecify)	
C	ding h. After fune	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Injury	M	Worl	k? Yes 2 □ N		04. 198611100 1	now injury	y occurred		
Division	or Attendation deati	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of Ir	njury - At hor tc. (Specify)	me, farm, sti					8f. Location (S City or Tox			Rural Route N	lumber,
	Hos Fun Flun	edical C		nysician: To the bes miner: On the basis and manner s	of examinati										se(s)
7	To the within 2 To the complet	M	29b. Signature and title of certifier.	fhumai	na,	MD		_	9 number 75 26	4			_	onth, Day, Yea.	
	3/		30. Name and address of person who LOVEEN JPUTHUL	completed cause of	death (Item	23a) (Type,	Print)	COAD	SILV	VERS	SPRIN	6, N	1D 21	10904	
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signat		arte)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	laryland /	-	artment of F ctificate of			giene Reg. NG		00015
			Decedent's Name (First, Middle	ə, Last)					2. Date of Dea	ath	. U U 5	8. Time of Death
	Physici: /Medic		Doris Marie	Atkinson					Month 02/0	1/2	005 Year	16:16 M
	Examin		4a. Facility Name (If not institution	i, give street and number)			r Location of Death	h	1	County of Death	
			Carroll Coun		a 1 ge (In yrs. last b	Sanda ata)	Westmir	ister If Under 24 Hrs.	8. Date of Birt		arroll	lane (State or Fornian
П	Funeral Director		5. Social Security Number 214-03-3611	6. Sex 1 ☐ M 2 ☐ F	88	Yrs.	Months Days	Hours Min.	1 Month Da	y./Y9ag	16 Mary	place (State or Foreign htry) 7 Land
	pu 🛊 🗀 🗆		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	wn or Lo	cation				1	0d. Inside City Limits
	sho	JO.	Maryland Carr		Westn							1 ☐ Yes 2 X No
	288-1	ect	10e. Street and Number	011	Wesch	ILLIC	10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	3a or	Funeral Director	665 Whisperi	ng Meadows	s Court	_	21158			Uni	ted Sta	ates
	ms 2:	nera	11. Marital Status	12. Was Deceden	t Ever in U.S.		Was Decedent of h	lispanic Origin? (S	pecify Yes or No	-	14. Race - Americ	
21215-0036	72 hours after death with the Maryland netural; or Items 23a or 28e-f show diest Execultier must be notified at		1 Never Married 2 Marr 3 XWidowed 4 □ Divorced	If Yes Give	No		1 ☐ Yes 2X No	Specify:	to rican, etc.)		Black, White, Specify: W	nite
9-0	72 hours "netural", dical Exp	Completed by		it's Education st grade completed)	168	a. Deced	dent's Usual Occup	ation during most of wor	rkina	16b. Ki	nd of Business/In	dustry
21	c * 3	nple	Elementary/Secondary (0-12)	College (1-4or			kind of work done DO NOT use retired	d)			blem	
	Hygier Hygier ther th	S	11	(4)	Se	eams	stress	10 Mathada Nar	me (First, Middle,		nufactu	er
and	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle,					Mamie !		Maruerr	Junanie)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Irs M.	ို	Albert Johns 19a. Informant's Name/Relations		19	b. Mailir	ng Address (Street			er, City o	r Town, State, Zig	Code)
Ma	and 2 s salth an n 27 Is ier treu											100
ē,	of Health item 27 other tr		Elaine Kette	Imail Baay.	20b. Place	of Dispo	sition (Name of matory or other pla	02/	0 ¹ 5 ^t / 200	20c. Lo	ocation - City or To	own, state
E	Pages nent of i int: If it		1 ■ Burial 2 □ Cremation 1 ■ Donation 5 □ Other (S	3 Hemovai from Stati		wr	idae Mer	morial 1	Park	How	ard Co.	. Marylan
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic <u>once.</u>		21. Signature of Funeral Service	gense 2	(2)	D 22	Name and Address Name and Add	ss of Facility Weber Ondson	Funera] Avenue	L Ho Bal	mes P.	A. MD 21229
	_		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Comy one cause on each	T 100							Onset and Death
	/Medical		resulting in death)	aDue to (or a	s a consequence	e of):	NEW					مُسَامَ
	Examiner		Sequentially list conditions.	b. Ahd	lome	2	Deus	,				Quly_
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	e of):						١ ٨
	eecute and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	Sa consequence	e of):				-		Tuky
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687	ificate g phys as the	edical		a. <u>13-55</u>		0	real	TOUTE				
Вох	anding use a	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal dear	th 3	Ectopic pregnanc	,			23d. Date of deliv	,
	that the death certif ed by the attending detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No		at time of death		Other (specify)	,			Month	Day Year
P.0	res that the de signed by the a l be detached t	Phys	9 Unknowh		h	T I I	- A - A - A	in Death	220 Dide	obassa u	en contributo to t	he cause of death?
	es De	Ď	Part II. Other significant conditi	2 A.F.h.	_	jin thei u	ngerrying cause giv	ren in Part I.	1 🗆		XNo 3 □ Proi	
ecords,	neen nould	eted	1,01045emo	C14(4)C1								
Rec	e la has	Completed							24a. Was autor perfo		prior to co	opsy findings available impletion of cause of
al	ilcien: The l certificate ha rector, page		05 141							2 2 0	1 🗆 Yes	2 No
Vital	Physicien: this certificated rail director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 ER/C	Dutnatier	nt 3□ DQA Ot		ath (Check only o		6 ☐Other (Special	fvl
of			27. Manner of Death	28a. Date of In	jury 28b	. Time o		ry at	28d. Describe			97
ion	Attending F r death. ector: After by the funer	atlo	1 Natural 5 Pendi 2 Accident invest	ng (Month, E igation	Jay 16ai)	Injury		Yes 2 □ No				
Division	r Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace of I	njury - At home, etc. (Specify)	farm, sti	reet, factory, office		28f. Location (City or To	Street an wn, State	nd Number or Run	al Route Number,
	urs aft rel Di	Cer)	11		h			
	To the Hospitel or Attendi within 24 hours after death, To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physicien: To the best Exeminer: On the basis and mariner:	of examination	ge, deat	bocaured at the ti	me, date and place opinion, death occu	e, and due to the urred at the time,	date and) and manner as s d place, and due t	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of pertific	ar //		/	29c. Licens				te signed (Month,	
•			-	4	5/0/		1)3	579,49		Feb	2,157-	2005
11	7		30. Name and address of person	who completed cause of	death (Item/23a	_				_1	2 21.1	2005
1			31. Date filed (Month, Day, Year	1000 della	strar's Signature	n ċ	Sherust	heme,	Weston	w	sen in	2 X117+
	St Regist	ate rar	FEB 0	4 2005	eia S	M	parti	·				

		1	For Amend Item 24	State of Maryland a per Verb., C	840°02 Cer	then of H	lealth and M Death	lental Hygie Reg.	ne 2005	03246
	<u>.</u>		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Nancy Lee Atw	ill					31, 2005	4:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Death	
	Lxaiiiii	31	Holly Hill Manor		i	Towso	on		Baltimor	e
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Director		219-28-1989	M 2⊠F 71	Yrs.	Months Days	Hours Min.	Jan 16,	1934 Mai	yland
	ס	į	Usual Residence of Decedent							10d. Inside City Limits
	how		10a. State 10b. County	10c. City,	Town or Loc	cation				1 ☐ Yes 2 ☑ No
	e Ma la-f	cto	Maryland Baltimor	·e	Towson	<u> </u>				
	or 28	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	23e		8303 Thornton Road			21204			USA	
	r des	Funeral	TT. Wasta States	Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Rece - Amer Black, White	
20	or it	by Ft	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X	1	☐ Yes 2X No	Specify:		Specify:	White
Maryland 21215-0035	ural'	d b	3 X Widowed 4 □ Divorced	Year or Dates:	16a Docad	ent's Usual Dccup	ation	16	b. Kind of Business/li	
2	"nat	Completed	15. Decedent's Educi (Specify only highest grade		(Give	kind of work done	during most of work d)	ing	b. Italia of Basillosa ii	, and any
2	withir	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+) n/a		ervisor			Rope	er
N D	filed within 72 hours after death with the Maryland Hygiene. Other than "natural; or items 23e or 28e-f ehow ent, the Medical Exam not noted by motified at		17. Father's Name (First, Middle, Last)	n/a	Jup		18. Mother's Name	e (First, Middle, Ma	iden Sumame)	-
au	d be antal	o Be	John Griff	in			Lore	etta	McGee	
2	mark mark	ဥ	John Grift 19a, Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street			city or Town, State, Z	ip Code)
<u> </u>	d2 s th ar 27 io trau		Loretta Simon/Daugh		830	3 Thornto	on Road,	Towson, M	aryland 2	21204
ο̈	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination with the multiple at ODEs.	11 3	20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of natory or other place		Date 20	c. Location - City or 1	own, State
ᅙ	Pages nent of I nnt: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	*		on Cremat		aurel, Mai	rv1and
Baltimore,	permit. Pag Department Important: any injury c	1	21 Signators of Fun Iral Service Liceb #							
Ba	permit. Departr Importi any inj		Bryan W. Clary	aret	L	emmon Fur	neral Home	e of Dula	ney Valley m, MD 21	y Inc.
			23a Pert1 Ener the disease or complic	ations that caused the death.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arrest	ills FID ZIC	Approximate
	-00.000		shock, o heart ailure. List only on	e cau lse o n each line.						Interval Between Onset and Death
	Physician /Medical	11	disease or condition resulting in death)	Due to (or as a conseque	ence of:					5 Jays
b	Examiner			Due to (or as a conseque	erice or,					
	统。 "**	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	petru	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						1	
	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequent	ence of):	,				
8760,	sicie s bur	cal	L _a							
89	flicate g phy as the	edic								
Вох	that the death certific ed by the attending p detached for use as	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnan		Tatania aragnana			23d. Date of deli	*
ň	death a atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de]Ectopic pregnancy] Other <i>(specify)</i> _	y		Month	Day Year
Ö	the ache	hys	9 🗆 Unknown	9□ Unknown				7		
S, D		y P	Part II. Other significent conditions con	tributing to death but not resu	lting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	3
rds	requires een sign hould be	pe P	dementia					1 🗌 Yes	2 □ No 3 □ Pro	obabiy 4 Donknown
00	law re as bee	olet						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Re	9 4	E						performe	d? death?	2 No
of Vital Record	ician: Th	a	25. Was case referred to medical				26. Place of Dear	h Check on one	110	
5		To B	avaminar?	ospital: 1 Inpatient 2 E	ER/Outpatier	nt 3□ DOA Dt			ce 6 Other (Spec	cify)
			27. Manner of Death		28b. Time o	f 28c. Inju		28d. Describe how		
Division		ig i	1 Natural 5 Pending 2 Accident investigation	(Month, Day Fear)	Injury		Yes 2 No			
/isi	l or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Stre- City or Town,	et and Number or Ru State)	ral Route Number,
á	pitel or At ours after c terel Direc filled in by	Certification:	4 Nomicide	building, etc. (Spechy,	,			ony or rounn,	J. 12.07	
	% E = >		29a. Certifier 1 Certifying Phys	sician: To the best of my knowner: On the basis of examinati	viedge, deat	h occurred at the ti	me, date and place,	and due to the cau	se(s) and manner as	stated.
	Ne Ho	edical	(Check only 2 Medical Examir ana)	and manner stated.	ion and/or in	vestigation, in my t	opinion, death occur	red at the time, bate	and place, and due	(0 (116 Cause(s)
	To the Hos within 24 hd To the Fun completely	M	29b. Signature and title of certifier			29c. Licens	se number	290	I. Date signed (Montl	h, Day, Year)
			n-American de Caración de Cara	MAN	D	7	7411	7 4	2/1	105
1	10/		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)	_	1.1	71-	
(Ted Houle	UD 7825	York	e Rd	Tows	on MAD	(120	7
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	140				
	Regist	rar	FEB 0 3 2005	Blown D	Sept.	West of				

	1	For State Registrar	State of M	laryland / De _l	partment of F ertificate of	Health and M Death		ene20	05	0324
) Invaiolon	1	. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day	Year	3. Time of Death
hysician /Medical	L	Nancy	S.	Aver	У		January		005	5:20 a M
Examiner	4.	a. Facility Name (If not institution, give		")	4b. City, Town, o	or Location of Death		4c. County	of Death	
		767 Parkers Creel			Deale If Under 1 Year	If Under 24 Hrs.	0.0.1(814)	Anne		
ineral rector	L	219-16-1336	9X	ge (In yrs. last birthda 80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 7	,1924	9. Birthi Cou Mary	place (State or Foreign ntry) Land
ed at	-	Usual Residence of Decedent Oa. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
notified at rector		MD Anne Art	ındel	Annapo	lis					1 ☐ Yes 2 😿 No
Sire	1	0e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Cou	ntry?
unerai Di		231 Gibson Road			214			USA		
by Funeral Director		Marital Status Never Married 2 ☐ Married Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	Μo	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2\(\times\)XNo		ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. Thite
		15. Decedent's Ec	lucation	16a. De	cedent's Usual Occup	pation	ina 1	6b. Kind of B	usiness/In	dustry
Completed		Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of work done . DO NOT use retire .emaker	d)	9	Own Ho	ome	
Be Completed	1	7. Father's Name (First, Middle, Last)		,		18. Mother's Nam	e (First, Middle, M	laiden Surnan	10)	
To E		Joseph L. Sacrey				<u> </u>	eth Faris			
7	ŀ	19a. Informant's Name/Relationship (iling Address (Street					o Code)
	-	Donald Avery (Son	1)		Parkers of			MD ZC		own. State
once.	1	1 XBurial 2 ☐ Cremation 3 ☐		G	position (Name of rematory or other pla	1				
9		* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Ligar		/ Cedar B	22. Name and Addre			Annapol A	LIS,	MD
Я	L	23a. Part1. Enter the disease, or com shock, or heart failure. List only	anti		12 Ridge	ely Avenue	Annapo	olis. M	1D_21	401
s the burial-transit adical Examiner		Sequentially list conditions, a.y. leading to annualists acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence of): is a consequence of): is a consequence of):						
Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	y			te of deliventh	ery Day Year
by	۱,	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause gr	ven in Part I.		acco use cont		he cause of death?
letec			< .	12. 1 B	- 0		24a. Was an		Were auto	opsy findings available
Completed			No	rul Pro.	ssar Hey	Inocaple.	autopsy perform 1 Tes 2	ed?	prior to co death? 1 Yes	ompletion of cause of 2 No
Be Com		25. Was case referred to medical examiner?	Hospital:				h (Check only one			
12		1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 ☐ Inpa 28a. Date of In (Month, D	iury 28b. Time	of 28c. Inju		ome 5 Resider 28d. Describe hor			tr) Sais Hane
cation		2 Accident investigation 3 Suicide 6 Could not b	1		M 1	Yes 2 No	296 Lengtin - /C:	not ned Mine-	201010	al Pauta Alization
Certification:		4 Homicide determined	286. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Str. City or Town,		er or Hur	ai Houte Number,
completely tilled in by the Medical Certifical				st of my knowledge, de of examination and/or stated.						
Me	-	29b. Signature and title of certifier	/	200	29c. Licen	se number	29	d. Date signe	d (Month,	Day, Year)
'		> RobA el	. Crel	UCC	D	2637	2	1/3	110	
	- 1	30. Name and address of person who Robert Greenfield		death (Item 23a) (Type		5/ 12/ 13	na well	, me	2	21401
State		31. Date filed (Month, Day, Year)					8			
State Registrar		FFB 0 4 2005	A Common of the second	strar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 16 per 15 pe

Galet.		Registrar 1. Decedent's Nam	ne (First, Middle, La	st)			rtificate of l		2. Date of De	Reg. No.			3. Time of Death
Physici	_	CAR	51	51/			BELCI	ter.	Month	Day		ear 005	0725 4
/Medic Examin		5. Social Security i	Number 8.5	OKines +	lospti	last birthday)	4b. City, Town, or		City	4c.	County of [Death	ice (State or Fore
ctor		072-24-		2 X] F	77	Yrs.	Months Days	Hours Min.	8. Date of Bir (Mopth, Da March 30	0,1927	S	Couintr taten	Island N
74		Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	ocation					100	d. Inside City Lim
fffed	ctor	PA	Chester		E	Iverson	1						1 □ Yes 2
at be no	ai Director	10e. Street and Nu 2 Stable					10f. Zip Code 19520			-	en of Wha	t Countr	y?
dical Exaction must be notified at	d by Funerai	11. Marital Status 1 □ Never Mar 3 X Widowed	ried 2 Married	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? T No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		4. Race - / Black, V Specify:		tc.
event, the Medical	Completed	(Spe	15. Decedent's Ed cify only highest gra ondary (0-12)	ducation ade completed) College (1-4or	r 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wo)	rking		nd of Busin	ess/Indu	istry
nt, the		12 Eather's Name	(First, Middle, Last)	4			Homemaker	40 Marks als No.	/5: 64:				
8 A B D	To Be		L. Roggenbu					Hester	_{ne (First, Middle} French	, Maiden S	Surname)		
traumatic	-	19a. Informant's N	lame/Relationship (Type, Print)		19b. Mailii	ng Address (Street a	and Number or Ru	ıral Route Numb	er, City or	Town, Sta	te, Zip C	Code)
other traume			lcher /Son				arker Stree	t Carlis1					
ŏ			sposition Cremation 3 5 5 Other (Specify		a a	emetery, crei	osition (Name of matory or other place S & Company		Date 1/2005		cheste		
any injury once.		21. Signature of F	neral Service Licer	1500			2. Name and Addres	Stevens Fu	neral Hom	e Inc.			
			. \ \ \ .				1501 Fast R	ort Ave. F	altimore	MD 212	30		
		Immediate Cause disease or condition	on	a RESP	IRAT	h. Do not ent	1501 East R	ort Ave. F g, such as cardiad			230	li C	Approximate nterval Between Onset and Death
dical	1	Immediate Cause disease or condition resulting in death)	(Final on	a. RESP Due to (or a	IRAT is a consequ iS	h. Do not ent	1501 Fast Fo	ort Ave. F g, such as cardiad			230	li C	nterval Between Onset and Death PAYS
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After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit of the control of the contr	To Be Completed by Physician/Medical	Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	onditions, mediate errying r injury s Last the pregnant emonths?	Due to (or a b. SEPS Due to (or a c. THCPA Due to (or a d. ————————————————————————————————————	IRAT as a consequence of pregnate at time of definition to resulting the consequence of t	uence of): Acre uence of): Acre uence of): and and and and and and and an	TALU2 FAILU2 FAILU2 TO Attended to the mode of dying and a second a	ort Ave. E g, such as cardiac L G, such as	23e. Did t 1 1 24a. Was autop perio 1 1 Yes	obacco us Yes 2 an psy primed? 2 (X)No one dence 6	3d. Date of Month se contribut No 3 24b. Were prior deatt 1 Other (S	delivery D e to the Probab a autops to comp h?	cause of death of the policy o
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	lo the Hospitel of Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examone)	vsician: To the best of my knowl iner: On the basis of examination and manner stated.	edge, deat n and/or in	vestigation, in my o	pinion, death occur	rred at the time,	date and	d place, and due to	the cause(s)
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amend item#9,24a-b, perFH, MD, G840, 2/4/05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Year **Physician** , C, Bradby 8:31AM 2005 -onnie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days) 61 Yrs. Months Days Hours Min. Feb. 28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2 □ F 219-38-0153 ,1943 Viri Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notilised at 1 XYes 2 □ No N/AMaryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 615 N. Dennison Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (32/9s 2 □ No 1 9 6 1 − If Yes, Give Year or Dates: 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, Item 2006. Maintenance Work 12th grade School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burrell Bradby Alma Denmark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Remona Bradby/ Daughter B815 MidHeights Rd Baltimore, Maryland21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/3/05 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cem. Crownsville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md21215 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or her if failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** brown injury Anoxic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit the attending physician and ched for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should ! arter been pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20KNo 1 XYes 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/2005 8 605 (Gunawardane MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manjula Greene Street Baltimore , MD 21201 Gunawardene 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State FEB 04

Registrar

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	To th To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Mo	onth, Day, Year)	
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	5		30. Name and address of person who completed cause of death (Item 2) Eric Bricker, Resident, W	00 1	Yorth W	olfe St	reet K	altimo	e MD 21287	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 4 2005 32. Projector's Signatur	re /s	linde					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend it em 2 per dvr /8840 2-7-05 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 3 Time of Death Dav Month **Physician** ADA BARZETTI 01 ebrug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA MARIS HOSPICE AT MERCY BALTIMORE N/A 8. Date of Birth (Month, Day, Year)
AUG. 11,1918 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months 86 Director 217-80-5321 NEW JERSEY Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f shov other traumatic avant, the Medical Examinar must be notified at 1X Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 705 S. POTOMAC itams 23e STREET 21224 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: WHITE "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within ; th and Mental Hyglene. 7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ATTILIO 2 MARINI MARY ANGELETTI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 705 S. POTOMAC STREET, BALTIMORE MD. 21224
Disposition (Name of Date 20c. Location - City or Town, State t of Health CARMELO GALOFARO/SON-IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Donation 5 Cremation 3 Removal from State 1 Donation 5 Other (Specify) ö permit, Page Department of Important: If any injury or once: SACRED HEART OF JESUS 2/5/05 BALTIMORE, MARYLAND 21. Signature of Funeral Strice Licenses 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME CONKLING STREET, BALTIMORE, MD, 21224 700 S. Contract of the 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death colorectal Immediate Cause (Final disease or condition resulting in death) Physician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 20 No Certification: To 1 Yes 3 DOA funara 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certific 2 2/2/05 410854 30, Name and address of person who concleted cause of death (Item 23a) (Type, Print) RISEberg Haldimore

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2005

32. Signature

			1 - Stete Registrer	State	of Marylar		artment of F tificate of		Mental Hygi	ene g. No.	5 03	254
	Physici /Medio		1. Decedent's Name (First, Mide Constance	Helen		Cl	napman		2. Date of Death Month January	2 ^{Pay} , 2005		e of Death 42 pmm
	Examir		4a. Facility Name (If not instituti 429 Capstan		umber)		4b. City, Town, o	r Location of Death	1	4c. County of Anne A		
	Funeral Director		5. Social Security Number 168–54–3542	6. Sex 1□ M 2√2 F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 12		Birthplace (Sta	te or Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State PA. 10b. Count Alleg			ty, Town or Lo	cation					a City Limits
	h with the 23a or 28e at be notifi	Funeral Director	10e. Street and Number 201 Farmer	est Drive	<u></u>		10f. Zip Code 150	071	10	g. Citizen of Wha	at Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28e-f show any injury or other treumatic event, If a Medical Examiner must be mailified at once.		11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 Tes	2 <mark></mark> 1 No ive	l l	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indiar White, etc. Whi	
21215-0036	d within 72 hu giene. Irre Madical	Completed by		nt's Education ast grade completed College) (1-4or 5+)	16a. Deced (Give jife. L Hom	ent's Usual Occup kind of work done o OO NOT use retired emaker	ation during most of wor di)	king	6b. Kind of Busin		
Maryland	ould be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle Alfred	, Last)		O'Key		18. Mother's Nam Kate	ne (First, Middle, Ma	aiden Sumame)	Kent	
	and 2 sho ealth and m 27 Is mu		19a. Informant's Name/Relation David Chapman	ship (Type, Print) SON		1652	Oakleaf I	and Number or Ru Lane Pitt	ral Route Number, 6 Sburgh PA	City or Town, Sta A. 15237	ate, Zip Code)	
Baltimore,	Pages 1 tment of H tant; If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Specify)	State		sition (Name of patory or other place natory			oc. Location - Cit		•
Bal	permit Depar Impor any in		21. Signature of Fun	611						napolis,		
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, a shock, or heart affure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	each line.	quence of):	ir the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approxir Interval	nate Between Id Death C
, P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Part II. Other significant condit	d	utcome of pregni birth 2 Feta nant at time of d	ancy Il death 3 🗆 eath 5 🗆	Ectopic pregnancy Other (specify) derlying cause give	en in Part I.	23e. Did toba	23d. Date of Month	Day	Year
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Division of Vital	ding Phys h. After this funeral dii	Certification; To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi invest 2 Accident invest 3 Suicide 6 Could deten	Hospital: 1 28a. Date (Mor igation not be pined 28e. Place	of Injury oth, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	ar: 4 ☐ Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, S	ce 6 Other (strinjury occurred		umber,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:	Medical C	one)		e best of my kno casis of examina ener stated.	wledge, death tion and/or invi	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the causered at the time, date	se(s) and manne a and place, and	r as stated. due to the cause	a(s)
V	To the within 2 To the To the complet	M	29b. Signature and title of certification of the signature and a ress of person the signature and a ress of person the signature and title of certification of the signature and title of the sign	well for	se of death (Item	23a) (Type, F	29c. License	3155	1 J G/1 n 13	Date signed (M	Jonth, Day, Year, J. J.	02/5
	Sta Registr	-	31. Date filed (Month, Day, Year FEB 0 3	2005	Registrati's Signa	ture	Ø.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ind item I per phys g840 2-4-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Vaar Carla 12:35 PM Canapp 4a. Facility Name (If not institution, give street and number) 2005 /Medical Lebruary 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayvier Mederal Center 5. Social Security Number 6. Sex , 7. Age (In yrs. last birtho Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 25 F Days Hours Director 54 219-58-0003 07/19/1950 MD Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City. Town or Location 27 is marked other than "natural", or Itema 23a or 28e-1 show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Lava Court, Apt death Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after un and Mental Hygiene. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify:
White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dental Dental Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Charles Henry Haederer Ruth Elizabeth Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If Itam 27 Is rr any injury or other traurr 2002. Corinne Halvorsen 503 Bowleys Quarters Rd Apt. C Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Feb Chesapeake Crematory Inc.

22. Name and Address of Facility Beltsville, Maryland 2005 21. Signature of Funeral Service Licensee M00986 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** Obstructivo Gronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Ulmonary Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cronam 24a. Was an autopsy 2 25. Was case referred to medical examiner? Diabetes 2 No 1 Yes 1 ☐ Yes Division of Vital : After this certifice funeral director, r or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 acces v MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 Lacera Hangok, Johns Hopkins Bayvicco Med Ctr, 4940 Eastern Aug Baltimon 31. Date filed (Month, Day, Pear) egistrar's Signature 32. State

DHMH 17 Rev 1/2001

Registrar

FEB 04

2005

Eren & Speck

Richard Crawford 05-00632 Please Type or Print in Black Indelible Ink Ensure All Copies	
d1 Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg	giona a a a
1 = State Certificate of Death	Reg. No. 03256
Decedent's Name (First, Middle, Last) 2. Date of Dea	ath 3. Time of Death
Medical Richard W. Crawford January	7.25, 2005 3:05 P M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
3300 Kenyon Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birthday Archives Archiv	Baltimore 9. Birthplace (State or Foreign
1XIM 2 F Months Days Hours Min. (Month, Day	Country) Country) Virginia
Usual Residence of Decedent	10d. Inside City Limits
λλ	1 XYes 2 □ No
MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
3300 Kenyon Avenue 21213	USA
	14. Race - American Indian, Black, White, etc.
90000000000000000000000000000000000000	Specify: White
3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surveyor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surveyor 18. Mother's Name (First, Middle, Last)	16b. Kind of Business/Industry
College (1-4or 5+) Elementary/Secondary (0-12) College (1-4or 5+) Surveyor	
Surveyor 17. Father's Name (First, Middle, Last) Surveyor 18. Mother's Name (First, Middle, Last)	Land Surveyor
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	
Charles Crawford/Brother 534 Cedar Avenue Vinton, V	A 24179
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 3	20c. Location - City or Town, State
20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 1 Duling Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Fune	Keyser, WV
Howard E. Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. Charles Crawford/Brother 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Service Licenses 25 S. Main Street Keyson	eral Home er, WV 26726
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line.	•
Physician Immediate Cause (Final disease or condition Athorno Legatic Corol (CVC) Sci. (c. d.)	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions b	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
Due to (or as a consequence of):	
Due to (or as a consequence of): O	
X 9 IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Month Day Year
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230. Was deceded to frequent in the past 12 months? O'd's graph of the state of th	bacco use contribute to the cause of death?
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autops	sy prior to completion of cause of
A Table 1	2 No 1 Yes 2 No
1 Inpatient 2 ER/Outpatient 3 DOA State 4 Nursing Home 5 Reside 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 4 Work? 28d. Describe how 28d. D	ow injury occurred
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27. Manner of Death 1 Natural 2 Natu	treet and Number or Rural Route Number, n, State)
2 Accident 3 Suicide 4 Homicide 6 Could not be determined 10 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the creating one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. eignature and title of certifier 29c. License number 22c. License number 2c. License nu	ause(s) and manner as stated.
29a. Certifier 29a. C	ate and place, and due to the cause(s)
29c. License number	9d. Date signed (Month, Day, Year)
	January 26, 2005
30. Name and address of person who completed cause of Geath (Item 23a) (Type, Print) ATRICIA ON CA COLLANDIA (Type, Print) Penn Street, Baltimore,	Maryland 21201
State Registrar State	IMI YIMIN ZIZUI
Registrar FFB 0 4 2005 Address At Application of the American Application of the Ameri	

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		-	State of Maryland / De State of Maryland / De	partment of Health and Nertificate of Death		ene 2005	03257
	Dhomist		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Kilmer Daughton		January	29, 2005	4:35A. M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			3355 Old Line Avenue	Laurel v) If Under 1 Year If Under 24 Hrs.	la Data (Dist	Anne Aru	
	Funeral Director		5. Social Security Number 230-03-8825 6. Sex 7. Age (In yrs. last birthda Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Jan. 18,	1918 9. Birth	nplace (State or Foreign untry) Uginia
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Manyi -f sho	ō	MD Anne Arundel Laurel				1 ☐ Yes 2 🂢 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	h with		3355 Old Line Avenue	20724		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarities rotal be retilled at once.	Completed by Funeral	The state of the s	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
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anc	i be fi	Be	Thomas E. Dalton		e (First, Middle, M E. Carte		
Maryland	should id Me mark matic	ပ္		iling Address (Street and Number or Rur			in Code)
	ith ar			355 Old Line Avenu			
ľe,	s 1 ar f Hea itam otha	Ì	20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or	
Ë	Page lent o nt: if ry or		1 Diburial 2 Cremation 3 Removal from State	ans Cemetery 2/3/	2005	Crownsvill	e. MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility F. 7601 Sandy Spring	leck Fund	eral Home,	Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not stock, or heart failure. List only one cause on each line.				Approximate
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COL	w require been si	iete			24a. Was an		topsy findings available
of Vital Records,	The ate h page	Completed			autopsy perform	prior to c	ompletion of cause of
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o		: To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Total of Dox Total sing I to	ome 5 Resider 28d. Describe hov	rce 6 □Other (Spec vinjury occurred	ify)
on	iding Phy th. After thi funeral o	tion	1 Natural 5 Pending (Month, Day Year) Injur 2 Accident investigation			, m, at y dodd. To a	
Division	or Attending after death. I Diractor: After din by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diraci completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, did 2 Medical Examiner: On the basis of examination and/o and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	Day, Year)
			· aungarenson 150	D16619	2	FEBRUARY	2, 2005
/	1011		30. Name and address of person who completed cause of death (Item 23a) (Ty) C.VERGARA - SOARES 8200 PROFE	SSIDNAL PLACE,	LANDOV	ER, MD.	20785
	Sta Registi		31. Date filed (Month Day Year) 4 2005 32. Registrar's Signature	Spelle			

amend item#10f, perfH, G840, 2/7/05 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARGARET 4, 250 A^M FEB 2005 E. DENDLER /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIDGEWAY MANOR NURSING HOME CATONSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M **Director** 85 1919 PA AUG 20, <u> 181.05.2721</u> Usual Residence of Decedent death with the Maryland wode 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f showner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 5609 EDMONDSON AVE 21229 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Mudical Examiner Black, White, etc. filed within 72 hours after Hygiene. 1 Tes 2 No 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced "natural', $\mathbf{X}\mathbf{X}$ WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 8 LABORER GARMENT_FACTORY and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT_SNAVELY HARRIET CHURCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5609 EDMONDSON AVE CATONSVILLE ,MD 21229 If Item 27 EDITH JONES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Itel any injury or oth 1 X urial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) ELAN MEMORIAL PARK BLOOMSBURG, PA 2.7.2005 21. Signal re of Juneral Servic Licentee 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY FYNK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List on work cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or indition resulting in death) Almoneny Obstavetive **Physician** DISEGNE monic Seulcul /Medical Due to (or as a consequence of): long Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence or). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown n signed by tt. 1 be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed astiden certificate Janualen 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Yoursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 187541 Feb 4, 2005 aug uns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATIA MD, 4367 Hollins Flory Rd, Baltimore, MD-21227 32. Regetrar's Signature 31. Date filed (Month, Day, Year) State FEB 04 Registrar SERAR S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 03259 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3 FEBRUARY EDNA BURNSIDE HOWARD DEVEREUX 2005 05:35a M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BROADMEAD COCKEYSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) 06/05/1907 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 🖫 F 214-22-6418 97 ILLINOIS Director Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28e-f show Examiner mant be nutified at 1 Yes 2 No Director BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 13801 YORK RD or items 23a 21030 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 ⊠Widowed 4 □ Divorced "natural". other than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4YRS Elementary/Secondary (0-12) EDUCATION TEACHER othar traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental h is marked o permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events. LYMAN AMBROSE BURNSIDE ANNA MUSSELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN B. HOWARD (SON) 6611 WEMOUTH CT. BALTO., MD 21212. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ARLINGTON NATL. 03/08/2005 ARLINGTON, VA. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS SONS 1692 1YORK RD MONKTON, MD.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 1□ Yes director, Be 25. Was case referred to medical examiner? 26. Place 1 Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 (No 3 DOA 1 Inpatient 2 ER/Outpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

3

Box 68760.

P.O.

of Vital Records,

Division

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Jime of Death **Physician** Dillon Year James 2:30 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Oeath **Examiner** 1839 Brett Court Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1939 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral №** M 2 F Days Hours Min 236-62-7342 65 Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. State f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner rivel by notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Be Completed by Funeral Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1839 Brett Court 21401 or items 23a IISA Pages 1 and 2 should be filled within 72 hours after death nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other than "natural; or items 23 array or other traumatic event, if a Medical Examiner usal ray or other traumatic event, if a Medical Examiner usal 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1□ Yes Ž No White 3 Widowed 4 Divorced Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) L. Norman Dillon Margaret ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1839 Brett Court Annapolis MD 21401 19a, Informant's Name/Relationship (Type, Print) Brenda Dillon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. Rosedale Cemetery Jan 31,2005 Martinsburg West VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li-22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD Jahres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician elod 1ast disease or condition resulting in death) /Medical Due to or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Completed by Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Oescribe how injury occurred Certification: After 1 Natural Injury 5 Pending after death.

Diractor: Aft in by the fur 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 900 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 9:15 A M **Physician** Decker Lawrence Jan 30 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1**X** M 2□ F 91 28,1913 Poland Feb. 127-12-5947 Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Peges 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
set: If item 27 is marked other then "natural; or iteme 23s or 28e-f show ant; if item 27 is marked other then "natural; or iteme 25s or 28e-f show any or other traumatic event, the Maryland Exacting or man be notified at 1 ☐ Yes 2 X No Director Annapolis Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2900 Shipmaster Way, #312 21401 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XXIO 1 Never Married XXMarried White 1 ☐ Yes 2X No Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturers Representative Cookware 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mindell Asher Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit Peges 1 and 2 s Department of Health ar Importent; if item 27 is any injury or other trau once. 2900 Shipmaster Way, #312, Annapolis, MD 21401 Gertrude Decker (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2005 Annapolis, MD Kneseth Israel Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): years Examiner oar Kinsun disea. Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ettending physicien by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death Check onl. one funeral director. 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No efter death. investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 | Homicide within 24 hours e To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Function (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 05181 Jan 30,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite Zul Halidas CT Ma /ta Matthew 2 132 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Reg. No. CU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Mae orothu 9:12 January /Medical 2005 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Bultimore Hospital or If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth Month, Day, Year Birthplace (State of Foreign Country) **Funeral** 219-12-5166 10 M 20 F Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumetic event, the Medical Examiner must be notified at Be Completed by Funeral Director 1 Yes 2 No attimore 10e. Street and Number 10f. Zip code 10g. Citizen of What Country? ō or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Amed Forces'
1 Yes 2 If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4or 54) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 it of Health at 1 item 27 i Date C. Location - City or Town, State other t 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition Date 1 Deurial 2 Cremation 3 Removal from State ö Department Importent: If any injury or once. • □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Greene Fundral Sinc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Obstructive Polmonary disease or condition resulting in death) Chronic years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Tes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certiflcation: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 January 31, 2005 0.0 30. Name and address of person who compared cause of death (Item 23a) (Type, Print) Hospi Baltimone Gardyn 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gertrude Ellis 1:45 a. February 1, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Community Williamsport Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 Ø F Director 213.28.1216 September 24, 1928 **Maryland** Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21795 U.S.A. 8605 Neck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. church office Elementary/Secondary (0-12) College (1-4or 5+) secretery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Emma Louise Velton Thomas McDonald Small 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Neck Road Williamsport, MD 21795 Mr. Russell Ellis Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury 4 □ Donation 5 □ Other (Specify) 02/05/2005 Columbia, MD St. John's Lutheran Church 21. Signa ure of Funeral Service Licenses 22 Name and Address of Facility any ir Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which could be considered to the course of the co Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the all 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2/2 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director. Be eferred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3□ DQA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of october 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Redistrar's Signature State Year) Registrar

			1 - For State Registrar	State of Man		artment o			giene 005	03264
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day Year	3. Time of Death
	/Medic		ALICE M. EATON					Janua	M 31 200	5 07:05AM
	Examir	ıer	4a. Facility Name (If not institution, give		}	4b. City, Tow	m, or Location of De	ath	4c. County of De	ath
	Euroval		5. Social Security Number 6. Sex	ising +	n yrs. last birthday	If Under 1 Ye	ear If Under 24 H		th 9 B	otholace (State or Foreign
и	Funeral Director			M 25 89			ays Hours M	in. (Month, Da		rthplace (State or Foreign Country)
	p.		Usual Residence of Decedent			1		2/17/	1915 Mai	ryland
	ith the Marylan or 28e-f show	-	10a. State 10b. County MD Harford	10	Oc. City, Town or L Whitef					10d. Inside City Limits 1 ☐ Yes 2X No
	he M	ectc							-	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show Is Madical Examinar musi Le notified at	Funeral Director	1627 Doolog Poad			10f. Zip Coo			10g. Citizen of What C	Country?
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(0	or Item	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No			of Hispanic Origin? Cuban, Mexican, Pu-	erto Rican, etc.)		ite, etc.
93	rel', c	Ď.	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify:		Specify: V	White
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Oc	ecupation one during most of watered)	vorking	16b. Kind of Busines	s/Industry
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7	be filed within 72 hours after death with the Maryla Ital Hyglene. Id other then "naturel", or items 23e or 28e-f ahov event, its Madical Examinar must be notified at		8 17. Father's Name (First, Middle, Last)		Packe	T	18 Mother's N	lame /First Middle	Maiden Sumame)	.urng
an	ould be filed Mentat Hygi arkad othar atic event, I	To Be	William Rowley					. Mullin		
Maryland 21215-0036	E E E	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mail	ng Address (Str	reet and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
	D =		Janet L. Jourdan/I	aughter	1627	Dooley	Road, Wh	iteford,	MD 21160	
ore	of He of He Mitan		20a, Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ R		20b. Place of Disponentery, cre	matory or other	place)	Date /2005	20c. Location - City o	
Ĕ	Pages ment of lite		`4 □Donation 5 □ Other (Specify)		St. Mary	's Ceme	tery 2/4	1/2005	Pylesville	e, MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If itam 2 any injury or other 2005.		21. Signature of Funeral Pervice License	Leve			neral Hame,	Inc.,600 Ma	ain St.,Delta,	PA 17314
			23a Part 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the	e death. Do not en	ter the mode of	dying, such as card	iac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pu	lmonar	y Em	bolisin	n	FewA	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					hous
		5	Sequentially list conditions, if any leading to immediate	Due to (or as a co	onsequence of):					
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9	ing ph e as th	Med	IF FEMALE:							
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	he de	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5 L	Other (specify	")			54 , 754.
, P.O	res that the digned by the be detached		Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Vital Records,	quires n sigr uld be	d by	C	homic E	36struc	time Pu	Imony]	Beare 101	Yes 2□No 3□P	robably 4 Unknown
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æ	The lav	Completed	7	o by doct				autop perfo 1 ☐ Yes	rmed? death?	completion of cause of
ita		Bec	25. Was case referred to medical	C - 9 - C - C	<u> </u>		26. Place of D	eath (Check only o		2010
of <	d is	2	examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 Other (Spe	ecify)
ב	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury		njury at Work?	28d. Describe h	now injury occurred	
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Division	after death after death Director: , d in by the f	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)	eet, factory, on	ce	City or Tox	Street and Number or R vn, State)	urai Houte Number,
	To the Hospitel or Attanding within 24 hours after death. To the Funaral Director: Afte completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	ier: On the basis of ex	amination and/or in	h occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
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	F ≥ F ŏ			RZA A-18	ATG, M	DD	43/15		1-31-1	
	21		30. Name and address of person who co	mpleted cause of death	h (Item 23a) (Type,	Print)	P	40 D	1-31-0-	
	Sto	•	31. Date filed (Month Day, Year) 4 2		Signature	OSESSE !	Groce	2/11/	21018	
	Sta Registr		FEB 0'4 Z	005 32. Redistrar's	The form					

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb 1, 2005 Edna Mae F1vnn 9:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕏 F Director 120-14-5443 82 Yrs Jan 26, 1923 New Jersey Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-1 show 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural; or Items 23a or 28a-1 show traumatic evant. The Modical Examination must be motified at 10d. Inside City Limits Prince George's Forestville 1 ☐ Yes 2 X No Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20747-1026 2130 Brooks Drive # 214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Completed by Specify: White 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) File Clerk/Telephone Operator Teamster Union 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>QNC8</u>. Be Hattie C. Stone William H. Maxson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Erhardt (Daughter) Hyattsville, Maryland 20782 5815 33rd Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 2005 20c. Location - City or Town, State Feb. 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Christ Episcopal Ch. Cem Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral HOme, Inc. MO1422 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Carcinoma of Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2□Alo death? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? hospice 1 ☐ Yes 2 😾 No Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this House 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation efter death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rando O. D23743 February 2, 2005 30. Name and address of person who completed cause of death (Item 2 ype, Print) Martin Weltz, M.D. 7525 Greenway Center Drive #205, Greenbelt, MD 20770 32 Pagistrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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		,	For State Registrar	State of Marylan		rtificate of L				15 03266
			Decedent's Name (First, Middle, Last)				Joann	2. Date of Dea	ıth	3. Time of Death
	Physicia		William Allen	Fleto	cher			Januar		05 12:50 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Januar	4c. County of	
			Millenium Health &	Rehab. Cente	\mathbf{er}	Edgewate	er		Anne	Arundel Co.
	Funeral		5. Social Security Number 6. Sec		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 11		9. Birthplace (State or Foreign Country)
	Director		578 18 8726 XX-	M 2UF 83	115.			July II	, 1921	Washington DC
	yland		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	a-1 st	cto	Maryland Anne Aru	ndel	Edge	ewater				1 ☐ Yes 2 ☐ No
	ith the	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	rall	144 Washington			2103			United S	
	itams itams	nu	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces? 1 X Xes 2 No WW	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	- American Indian, White, etc.
336	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	**	1□ Yes AN No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupa	ation	ing	16b. Kind of Busi	iness/Industry
2	ithin Jen Mes	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired)	9	70	
2	filed w Hygier other th	ပို	17. Father's Name (First, Middle, Last)		Mair	ntenance	10 11-11 1 11-11	(77)	Pepco	
anc	ntal Ped of	To Be	Raymond O. Fletcl	ner			18. Mother's Name		ollebaugl	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than sumatic avant, The M.	ř	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a				
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinar must be notified at once.		Marilyn H. Fletch		P.O.	Box 489,	78 E Str	eet, Lo	thian, M	20711
Baltimore,	of Health of Health fitam 27		20a. Method of Disposition	20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other plac	(8)	Date	20c. Location - C	ity or Town, State
Ē	permit. Page Department of Important: If any injury or once.		1 ☐ Burial XXX Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)			natory Fel			Clinton,	Maryland
alt	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	99						nc 6633 01d
a.	20 E 2 9	15.4	10000	<u> </u>		Alexandira		<u> </u>		20735
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the deat ne cause on each line.		1971 0000		or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	Ė	Immediate Cause (Final disease or condition resulting in death)	Cardiac	_A)	rbyth	mia			5 minures
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0	400	jer	saguer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):	c ween	o vogana	Di Cin	ease	
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760,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last	Due to (or as a consec	quence of):					
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Вох	death e atten	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	· ·
0	the by th	Physician/Med	9 Unknown	9□ Unknown						
s, Р	w requires that the sbeen signed by the should be detache	by P	Part II. Other significant conditions co	8 A .	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ord	equire en si ould l	ted	Diabetes m	ellitus				1 🗆 Y	′es 2 □ No 3	Probably 4 Minknown
Records,	aw as b	Completed by	Advance :	Dementis	·			24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of
E H		Con								ath? ☐Yes 2☐ No
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othi	26. Place of Deatl			
of	Phys r this ral dii	1: To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 La Ivursing no		lence 6 Other	
ion	Attanding I r death. actor: After by the funer	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No			
Division	Attanostractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti	reet, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Route Number,
Ö	spital or At ours after o neral Dirac filled in by	Cer	1							
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exemi	sician: To the best of my kno ner: On the basis of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the d red at the time, d	cause(s) and manr date and place, an	ner as stated. Indicate to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				(Month, Day, Year)
	F3F8		lyan	c. hu	ana.		0653			
	(×		30. Name and address of person who ca	ompleted cause of death (Itel	m 23a) (Tvpe				January	31, 2005
	37		Gyan C. Surana, M.	D. 5851 Deal	e Chur	·	, #16. De	eale, M	20751	
	Sta		31. Date filed (Month, Day, Year)	32. Faistrar's Sign	ature		•			
	Regist	ar	FEB U 4 20	105 Majore	15 1	120000 11				

KG		-	- State Amend Item 18	State of Maryland / &Unpend Item 23	Depa Ba pt	rtment of Health an II,27 per me ifficate of Death	d Mental Hy G840 2-17	/giene -05 (£ Reg. No.	05	03267
	Physicia /Medic	an	Decedent's Name (First, Middle, Last) Sherdina G.	ranger			2. Date of D Month January	eath 7 13,	2005 ^{ear}	3. Time of Death 2:06 P M
	Examin		4a. Facility Name (If not institution, give s 2805 Diamond Ridge			4b. City, Town, or Location of E Woodlawn	Death		County of Death Baltimor	: е
	Funeral Director		221-23-3332	7. Age (In yrs. last b	virthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of B (Month, D May 2.	rth ay, Year) 3,196	9. Birtho Coui Ports	place (State or Foreign htty) Smouth, VA
<i>j</i> =	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, To Bal	wn or Loc					0d. Inside City Limits 1 Yes 2 No
	3e or 28e-	Funeral Director	10e. Street and Number 2805 Diamond Rid	ge Road		10f. Zip Code 21 244		-	en of What Cour	ntry?
980	d within 72 hours after death with the Maryland Jiene. r then "netural", or items 23e or 28e-1 show the Marical Examiner musicen. Illied at	by	11. Marital Status 1 Marital Status 1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	If	Jas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F	? (Specify Yes or N Puerto Rican, etc.)	}	4. Race - Americ Black, White, Specify: Bla	etc.
21215-0036	within 72 ane. then "ne	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation 16 complete d) 16 College (1-4or 5+) 4	(Give I life. D	ent's Usual Occupation kind of work done during most of O NOT use retired) nager	f working	100	d of Business/In rriott	
Maryland	Q 12 D 9	To Be C	17. Father's Name (First, Middle, Last) Tom E. Granger	Sr.		Virgin	Name (First, Middle ia Silizah	, Maiden S	Sumame) nger-	
	nd 2 aith a 27 is r tree		19a. Informant's Name/Relationship (Type Jackie D. Butler			g Address (Street and Number of Wition Court,				
Baltimore,	permit. Pages 1 a Department of Hes importent: If item eny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🜠 ? 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State ROOSE	of Dispos tery, crem Velt Park	atory or other place) Memorial 1	Date /22/2005		sation - City or To Sapeake,	
Balt	permit. Departi import eny inj		21. Signature of Funeral Service License		1	Name and Address of Facility harles L. Steve 501 East Fort	ave. Balt	rmore	me Inc. MD 2123	30
	Pnysician		23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do e cause on each line. Systemic Sarco			rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,							
68760,	ficate be executed physician and is the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence						,
.O. Box 687	death certif e attending id for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 11 Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☑ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)		2	3d. Date of delive Month	ory Day Year
rds, P	ires that signed do be de	by	Part II. Other significant conditions cor Pre-eclampsia	tributing to death but not resulting	in the un	derlying cause given in Part I,		tobacco us	,	ne cause of death?
Vital Records,	The ate h page	Completed					1 Yes	ormed? 2 No	deayh?	psy findings available mpletion of cause of
of	ling Physici I. After this cer iuneral direct	atlon: To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation	iospital: 1 Inpatient 2 ER/C	Outpatient Time of Injury	Other	ng Home 5 Res 28d. Describe	idence 6		y) at scene
Division	2 # E C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		(Street and own, State)	Number or Rura	Il Route Number,
	To the Hospitel of within 24 hours at To the Funerel Completely filled it	edical	29a. Certifier (Check only one) 1☐ Certifying Phys 2☒∭dedicel Exemin	sicien: To the best of my knowled ner: On the basis of examination a and manner stated.	lge, death and/or inv	occurred at the time, date and pestigation, in my opinion, death	place, and due to the occurred at the time	cause(s) a , date and	and manner as s place, and due to	tated. o the cause(s)
	To t To t	×	29b. Signature and title of certifier	-Block	-S	O.C.M.E.			ry 14, 2	
			30. Name and address of person who co	ica- tollak M		Print) 1 Penn Street,	Baltimor	e, Ma	ryland	21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A	nauff #				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend state of Maryland & Pepartment of Mealth and Mental Hygiene Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Nancy Godsie 29th Jan 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes HealthCare n/a Baltimore ou ut 8. Date of Birth (Month, Day, Year) Aug 16, 1935 5. S**21** 9<u>9</u> 92 N9871 213-96-0886 6. Sex 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 Is marked other then "neturel", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at Funeral Director 1X Yes 2 No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Spence Street, Apt. 203 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Examiner Sewing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edwin Tharle Thelma Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sweitzer / Daughter 2037 Deering Avenue, Baltimore, Maryland 21230 Baltimore, Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 2/1/2005 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) exalerbation Physician days /Medical Examiner -Televation MT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardio myop athi Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Ś preumonia Yes 2 No 3 Probably 4 Unknown Completed peen Dehydration 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has page Chronic renal dysfunction 2□ No Vital 1 Yes 2 No 1 Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1. Inpatient 2 □ ER/Outpatient 3 □ DOA of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide 29a. Certifie 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 900 S SUN Catton 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Momas er 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) Kiche BALT MORE
If Under 1 Year If Under 24 Hrs. 105e0h 5. Social Security Number 6. Sex / 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days -71 Months Hours Min Director MARÝLAND Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or items 23a or 28a-f shov traumatic evant, the Medical Evaniner must be notified at 1 ☐ Yes 2 No Director DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 SA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18 coad nameer 17. Father's Name (First, Middle, Last) (8.) Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be arne YOU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name Pelationship (Type, Print) t of Health Munky 21234 othar t MARKWITTE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury of once. * 4 ☐ Donation 5 ☐ Other (Specify) 2lemetery 21. Signature, of Funeral Service Licenses 22. Name and Address of Facility MD 21234. BALTI MORE Sombelle alrolky EVADS FULLRAL CHAPFL 8800 HARFORD 23a. Part1. Enter the disertie, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only use cause on each link. Approximate Interval Between Onset and Death Immediate Cause (Final LaTeral **Physician** myoTrophi disease or condition resulting in death) /Medical Due to (or as consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by sign be 1 🗌 Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an N autopsy performed page. 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No Ď 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined

within 24 hours a

State Registrar

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and little of certifier 30. Name and address of erson who completed cay

2005

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MD

32 degistrar's Signature

of death (Item 23a) (Type, Print

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planer stated. 29d. Date signed (Month, Day, Year)

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Annie Goad 05-0652 SKH

Unpend item#23a, PII, 27, perME, 6840, 2/17/05 TT State of Maryland / Department of Health and Mental Hygiene () () 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GOAD FIL 3,000 /Medical January 26. 2005 8.44 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Peninsula Regional Medical Center Wicomico 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1□M 2¶9F Director 239-36-9731 JAN-23 Usual Residence of Decedent Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director JANAS DORFHESTER HURLOS Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code (COAL) Items 23a 4180 31843 F. 2.U 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 ō Specify: WHITE 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ZAYP KNITIER Knittinb 17.5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental H KOSZVZIJ (12212 2 NOTIAU AZZICO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) item 27 I GOAL HRIME HROUGEK DAVID MARYLAN 20c. Location - City o Town, State 20a. Method of Disposition Date F13.1. jo = 1⊠ Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. Donation 5 Other (Specify) CARROLLO VIRGINIA 3002 Funera Service Licensee 22. Name and Address of Facility TERNON FINANCE TO RODO MEMORIES M 212314 HARKY ME! PARTLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for t 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Munknown Diaetes Mellitus; Schizophrenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2∏ No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 1 XYes 2 No 2 xx R/Outpatient 3 ☐ DOA 2 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) ë 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Japiter v.
4 hours after deav.
real Director: Afr 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Wol O.C.M.E. January 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO M(1) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Mont FEB

DHMH 17 Rev 1/200

State

Registrar

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4 2005 distrar's Signature

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					Hospita						urnie				Anne	Aru	ndel	
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3 4	s 1 and f Health item 27 other to		20a. Method of Dis	sposition			20b. P	lace of Dispo	sition (Na	me of		Da	on, MI		cation - C	ity or To	wn, State	-
	Page nent o	١,	1 ☐ Burial 2 `4 ☐ Donation		3 □Removal t Specify)	from State		emetery, cren cro Cre	-		1	-7-20	05	Ralt	imor	ο λ	m.	
J. A.v.	permit. Pages 1 and 2 should be filed within Department of Headla and Montal Hygiene. Important: If item 27 is marked other than any injury or other fraumatic event, Ita Mappee.		21. Signature of F	uneral Service	Ферѕее				. Name a	nd Addres	s of Facilit	ty	lome, I		TIIIOL	C, 1	110	
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	withii To t	Σ	29b. Signature and	d title of certifie	or				29	c. License	number			29d. Dat	e signed	Month, L	Day, Year)	
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	10		30. Name and add	res of person	who completed	cause of de	eath (Item	23a) (Type,	Print)	11		٧	21	£ . N	7	land 1	1	
	Sta Registr		31. Date filed (Moi	nth, Day, Year,	005	32 Registra	r's 6)gna	DE DE	we !	yu	<u>u</u> §	<u>, w</u>		m	- «/	06	<i></i>	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOERI. EBICUARU EVELYND 11:50 AM 200! /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**K**)F 5-24-2020 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location If item 27 le marked other then "neturel", or iteme 23a or 28e-f show or other treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MI BALTIMORI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USM by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 □ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) $^{\prime}$ Homo maker NWN permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 le marked other any injury or other treumatic anona 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) Catherine Mc Cann Watters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulancy Valley Men Gar. 2-4-05 Timonion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RR RD. Timonium, mo 21093 PEACEFUL ALTERNATIVESTURGED+ CREMATION Center 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEP S13 Immediate Cause Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ERRORATED VISCUS signed by the attending physician and a be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 4 Pregnant at time of death 9□ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No P 1 Unpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) funeral 27. Manner of Death 1 SNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 Yes 2 No 2 🗌 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) FERRUARY 1,2001 phocompleted cause of death (Item 23a) (Type, Print) 30. Name and address of berson IM PORIN 31. Date filed (Month, Day FEBr) State Registrar DHMH 17 Rev 1/2001

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	Physici	an	1. Decedent's Name (First, Middle	, Last)	-				2. Date of De		3. Time of Death
	/Medic		William	M.	Harma	n			<u>JANUAR</u>	Y 31, 200	05 10:15a
	Examin	er	4a. Facility Name (If not institution	, give street and numb	oer)		4b. City, Town, or		ath	4c. County o	
			6501 ARROW WAY 5. Social Security Number	6. Sex 7.	Age (In yrs. Is	ast hirthday)	ELKRIDG	H. If Under 24 H	frs. 8. Date of Bi	HOWARI	9. Birthplace (State or Foreig
	Funeral Director		217-78-7554	1 ⊠ M 2□F	44	Yrs.	Months Days		JULY 14	ay, Year)	Country) Maryland
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	show	_	10a. State 10b. County	7		, Town or Lo	cation				10d. Inside City Limits
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	with t	ä	10e. Street and Number 6501 Arrow Way				10f. Zip Code 21075			10g. Citizen of W	hat Country?
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28e-1 show other treumatic event, I'm Medical Experient mark be notified at	by Funeral Director	1 X Never Married 2 Marri 3 Widowed 4 Divorced	Armed Force	es? Maria No	l It	Yes, specify Cuba	Specify:	ierto Rican, etc.)		white
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Z	d2 s th an treu		Grace Hickey -						, Elkrid		,
ē,	Heal Heal tem		20a. Method of Disposition	HOUNCE	20b. PI		sition (Name of natory or other place		Date		City or Town, State
JO T	ages ent of ht: If i		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (St		ate Bal	metery, cren trimore	Mash . Ci	em 2	-6-2005	Laurel	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other tre-		21. Signature of Funeral Service I		0	Ga 22	. Name and Addres	ss of Facility Ifman F	uneral Ho	ome @ Meado	owridge MP, Inc
			23a. Part1. Enter the discase, or	complications that cau	ised the death				lvd., Elk		D 21075 Approximate
	Pnysician /Medical Examiner	ı	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Complia Due to (or b.	cation:	ence of):	uscular d	lystrop	hy		Interval Between Onset and Death
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<u>α</u>	that hed b	by Pr	Part II. Other significant condition	ns contributing to dea	th but not resu	ılting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use contrib	bute to the cause of death?
rds	quires in sign								_ 1 🗆	Yes 2□No 3	B Probably 4 Unknow
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			30. Name and address of person	1							
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	ath v	-a	1701 Poplar					21216			U.S		
	er de	nue	11. Marital Status	Armed Fo	edent Ever in U	.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Oi Cuban, Mexica	rigin? (Specify Ye ın, Puerto Rican, ı	s or No- etc.)		American Indian, White, etc.	
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	To the Hospital or within 24 hours afte To tha Funeral Dir completely filled in	ledical	one)	Examiner: On the b and man	ner stated.	and/or if	reasingation, in in	y opinion, de	an occurred at th	- tane, date	ariu piace, and	due to the cause(s) Month, Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RALPH<u>HAYDEN</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2□F XX Months Days Hours Min. Director DEC 28, 087.09.2430 MONTANA Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits The Madical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No MD PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a or 8800 OLD HARFORD RD. 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes ❤️No 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 ₩idowed 4 Divorced Year or Dates: natural WHITE XXCompleted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING ADMINISTRATOR PROCESS CONTROL othari othar traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 shoutd be fill of of Health and Mental H I: If itam 27 Is marked oth IRENE WITT RALPH HAYDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 320 FOSTER KNOLL DR. JOPPA, MD 21085 RALPH HAYDEN III 20a. Method of Disposition

Y⊟ Burial 2 ☐ Cremation 3 ☐ Removal from State

14 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ita any injury or otl MAPLE GROVE CEM FEB 9, 2005 WALPOLE, MA 21. Signature Fineral S. Ivi 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY FIN 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only see cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? res 2 No 1 Yes 1 Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check onl on examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. М 1 □ Yes 2 □ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier ical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi within 2 the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State market FEB 04 Registrar 2005

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		•	for State Registrar	State of Marylar		rtificate of			leg. No.2 0 0	5 03276
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month		3. Time of Death
	/Medic	cal	Leonard Frank	Hall		4. 64. 7	.1	January	31 2005	4:30 A M
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	Funeral		2211	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign Country)
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	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
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	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jisal Essolier fourt be notified at	Funeral Director	11630 Glenarm Road			21057			USA	
	ltems	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black,	- American Indian, , White, etc.
5-0036	urs af	Ď	3 XWidowed 4 □ Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates: WW	II	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
2-0	72 ho	Completed	15. Decedent's I	Education	16a, Dece	dent's Usual Occup	ation during most of work d)	ina	16b. Kind of Bus	
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d 21	2 should be filed withir and Mental Hygiene. is markad other than aumatic avant, I'e Ms	CO	17. Father's Name (First, Middle, Las		recian	usi	18. Mother's Nam		Bethlehen Maiden Sumame,	
/lan	ould be Mental Markad c	To Be	Charles Hall				Wilhelmin	a Seibert		
Maryland	2 sho and h is ma auma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number	r, City or Town, S	itate, Zip Code)
≥	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiens. If item 27 is marked other than "natural, or Items 23a or 28a-f show it item 27 is marked other than "natural, or Items 20a or 20a-f show or other traumatic avant, If a Medical Examinating traumatic avant, If a Medical Examinating traumatic avant.	1	Leonard W Hall (Son)		19 Hi	dden Valley	Drive New		9111	Sh. or Town Chat
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra <u>once</u> .		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3	Removal from State	cemetery, crei	matory or other place	ce)			ity or Town, State
Ë	nit. Pa artmen ortant: injury e.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice			Mem. Gans. 2. Name and Addre	February 3	3 2005	Baltimore,	Maryland
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	110		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that sused the dear	th. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory ar	st,	Interval Between
	Physician		Immediate Cause (Final disease or condition	a. CONGE	STIVE	GAR!	AC FA	ILUR	13	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	141	TNEA	RC716	20	0 + 14
		i e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):	/ · (C	4	4		6 monts
	cuted nd ransit	Examin	Cause (Disease or injury that initiated events	CORDA	JARY	ARA	ERY	DISE	ASIZ	7 YEARS
.09	ie be executed /sician and e burial-transit	ai Ex	resulting in death) Last	Due to (or as a consec	quence of):	CIBR	2120	22		30 YE 425
687	certificate to inding physical is as the b			d. 1112		CHZV	47			30 TEARS
Box (leath certificate b attending physi	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7			23d. Date	of delivery
	s death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown		Ectopic pregnancy Other (specify)			Mont	h Day Year
P.O.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions		culting in the u	andorbing cause and	on in Cod I	230 Did to	hacca use contrib	oute to the cause of death?
ds,	w requires that the death s been signed by the atter should be detached for u	d by	ALZHEII	MERS DEM	ENT	7 <i>H</i>	enin ranti.	1 🗆 Y		B Probably 4 Unknown
cor	- Ω /n	iete	PARKINS	1a 2408	SBAS	3.5		24a. Was a	n 24b. We	ere autopsy findings available
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/ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			3700
of V	S 5	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2		The second secon	4 A ursing mo		ence 6 ☐Other	
on	fter	tion	27. Manner of Death 1 Valural 5 Pending 2 Accident Investigati	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ☐ No	28a. Describe no	ow injury occurred	d
Division	Attending or death. actor: After by the fune	Certification;	3 Suicide 6 Could not determine	be 28e. Place of Injury - At h	nome, farm, st			28f. Location (Si City or Town	treet and Number	or Rural Route Number,
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	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fo	edical	29a. Certifier (Check only one)	Physician: To the best of my known aminer: On the basis of examination	owledge, deat ation and/or in	h occurred at the tir exestigation, in my c	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and mani late and place, an	ner as stated. Id due to the cause(s)
	o the ithin 2 o tha omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	29d. Date,signed ((Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Porshia D. Holmes State of Maryland / Department of Health and Mental Hygiene State of Department of Health and Mental Hygiene G842 4-29-05 tas

Registrar Certificate of Death 05-0626 AKG Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Holmes Porshia 7:41 A M January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fort Washington
If Under 1 Year | If Under 24 Hrs. Fort Washington Hospital Prince George's 8. Date of Birth
April 16,2000 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2X F Yrs. Director 4 217-57-4580 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at |Maryland||Prince Georges Oxon Hill 1 XYes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 5 20745 503 Wilson Bridge Drive Apt. B-2 23e USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Black þ 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Child None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental F Holmes Taylor Is marked Clifton Pough Lisa Rena Harold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 s 1 and 2 s f Health an Item 27 is Lisa Taylor/ Mother 503 Wilson Bridge Dr. Apt.B-2 Oxon Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 2/2/05 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Odlessa Adams Funeral Home P.A. Aquasco, Maryland MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asphyxia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 rsician Physician/Medical the phy as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt 1 be c þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of chath? 1 Yes 2□No 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1**XX**es 2 □ No this funeral Found th, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? After Found 6:05 1 Natural 5 Pending after death. 1 ☐ Yes 2 No investigation 2 Accident A 1-25-05 Subject was asphyxiated 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 503 Wilson Bridge Dr Found at home Ft. Washington, Md within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 111 Penn Street, Baltimore, Maryland tolla VODICA 31. Date filed (Month, Day, Year) 32 State FEB 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 1:49 PM February 2005 Nellie E. Hinkleman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Greenhill Avenue N/AIf Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Yrs. Director 78 Sept. 9, 1926 217-22-8528 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State show 10b. County 10d. Inside City Limits rthan "natural", or items 23a or 28a-f shov the Medical Evanting must be notified at 1 X Yes 2 ☐ No Director Maryland N/A <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. death 4719 Greenhill Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other treumatic event, the Madic 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th, Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Snowden E1mer Elemay Zinc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. James Hinkleman/Husband 4719_Greenhill Avenue Baltimore MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/05/2005 Lorraine Park Cem. Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. m 6415 Belair Road Baltimore MD 21206 23a. Part1. Enter the disease, or controlled shock, or heart failure. List only of Approximate Interval Between Onset and Death tolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE CORONARY SYNDROME ACUTE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown þ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ VASCULAR ATHEROSCLEROTIC 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an certificate has 2 No 1 Yes Division of Vital Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 thesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury ospitel or Attence.
4 hours after death. 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aucon D 22 652 MD 2/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DV S SRINIVAS 5601 LOCARAVEN BLY 17 MD 21239 BLVD BALTIMORE Dr. S. SRINIVAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04 2005 Registrar

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		-	For State	State of Ma		artment of H			Z 11115	03279
			Registrar 1. Decedent's Name (First, Middle, Las.	1)		tinoato or t	Jean	2. Date of Death	. No.***	3. Time of Death
	Physicia		BERNARD		KANG	ETHE		FEBRUARY	1, 2005	2:55P. M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	/~ 1.00		Location of Death		4c. County of Deat	
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	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birti	hplace (State or Foreign untry)
	Director		A16 18-7777	M 2□F	52 Yrs.	Monard Days	Tiodis Mai.	JANO1,	1953 K	ENYA
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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	the h	Director	10e. Street and Number) / A		10f. Zip Code	IMORE	100	. Citizen of What Co	untry?
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ary	2 should be and Menta Is marked eumatic ev		19a. Informant's Name/Relationship (7				an <i>d Number or R</i> u	ral Route Number, (City or Town, State, 2	Zip Code)
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Baltimore,	permit. Pag Department Importent: I eny injury o		21. Sign atom of Furieral Service Loan	100	2:	2. Name and Addre	ss of Facility	BROWN	TR. FUNE	RAL HOME
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9		Med	IF FEMALE:							
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0.	the a	Physician/Me	1 Yes 2 No	4∐ Pregnant at t 9∐ Unknown	ime of death 5[Other (specify)				
Q	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	Inderiving cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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,	15		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		C.M.E.	FE	BRUARY 2,2	2007
1) 1		LABILLA	H AL	1		N STREET	BALTIMOR	E,MARYLAN	21201
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		1 _ For	State of Maryland	-	ent of Health a	and Mer		00-		
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/Medi Examii		4a. Facility Name (If not institution, give	street and number)		oity, Town, or Location o Perry Hall		anuary 31	L, 2005 Ac. County of Death Baltim		
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last		nder 1 Year If Under:	24 Hrs. 8. Min.	Date of Birth (Month, Day, Yea		nplace (State or Foreig untry)	gn
aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	,				10d. Inside City Limit	
or 28e-f	Directo	10e. Street and Number	MORE	BAL 101	MORE Zip Code	/	10g. (Citizen of What Co	1 □ Yes 2 N untry?	-
Dailillore, Marylalla Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show ship injury or other traumatic event. Ire Madical Examiner must be natified at 2008.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D If Yes,	alas ecedent of Hispanic Orig specify Cuban, Mexican	gin? (Specify n, Puerto Rica	/ Yes or No- an, etc.)	14. Race - Amer Black, White		
2 hours af atural, or lest Exem	by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	6a. Decedent's	Usual Occupation		16b.	Specify: OX	ZEAN	
od within 7 rgiene. er than "n	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO NO	f work done during most Tuse retired)	t of working		ry Cle	aning.	
ar yidalidi Zilki should be filed with nd Mental Hygiene. s marked other that umatic event, Itali	To Be (17 Eather's Name (First, Middle, Last)	Kim		18. Mothe	or's Name <i>(Fi</i>	irst, Middle, Maid Hee	an sulmame) UNL.		
Tand 2 shows the short of the s		19a. Informant's Name/Relationship (7	- wife	19b. Mailing Add	ress (Street and Number	al fil Date	MORE	MO DIE	ip Code) 336.	
Deficiency Pages Department of Pimportant: If ite any injury or of pages.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from State Come	SED NEW	or other place) HC HAPE1—	2-5-6	05 Fo	Location - City or T	own, state	,
permit. Departimport. any inj		21. Signature of Funeral Service Licen	SurotRy	IN ACK	e and Address of Facility 2 2 5 TUL HUTTUL	IMIVE.	SFUNE		MD 2109- BINALTON (Approximate	J.
Physician /Medical		23a. Part1. Enter the diseas in the shock, or heart failure. List or ly immediate Causa Final disease or condition resulting in death)	a_ Contact	Guusl	rot Woun				interval Between Onset and Death	
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cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequen	ce of):						
rifficate be of physician as the buri	Aedical	IE ECONO	d							
The Colids, F.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐Ectop	ic pregnancy r (specify)			23d. Date of deliv Month	very Day Year	
law requires that tas been signed by 2 should be deta	by P	Part II. Other significant conditions co	ontributing to death but not resultin	ng in the underlyi	ng cause given in Part I.			¥	the cause of death?	/n
vital necord stclan: The law require certificate has been si	Completed						24a. Was an autopsy performed?	prior to o death?	topsy findings available ompletion of cause of	le
VICAL SICIAN: T Certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:		Othor		heck only one)			=
ding Phys h. After this funeral di	n: To	27. Manner of Death	1 Inpatient 2 ER	Outpatient 3 b. Time of Injury 1	28c. Injury at Work?		5 Residence Describe how in		y at scen	e
tending leath. tor: Afte the fune	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	131105 1	Filled PM	1 □ Yes 2 🔼		Subj	ectsh	otself	
To the Hospitei or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	4 Homicide determined	building, etc. (Specify) -	nce		Ų.	Pevvy 1	tall MP	nercourt	-
ne Hosp n 24 ho ne Fune bletely fi	edical	29a. Certifier 1 ☐ Certifying Phyone 2 ▼Medical Exemple 2 ↑ Certifying Phyone 2 ↑ Certi	ysicien: To the best of my knowle liner: On the basis of examination and manner stated.	dge, death occu and/or investiga	red at the time, date and tion, in my opinion, deat	d place, and th occurred a	due to the sa use at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)	
To the To the comp	M	29b. Signature and title of certifier	00 1 7 1		29c. License number		29d. [ate signed (Month	. Day, Year)	
3		30. Name and address of person who d	completed cause of death) (Item 23	(Type, Print)	O.C.M.E	E.	Fe	bruary 03	, 2005	
		CAROLHAL	LAW Md	111 Pe	nn Street,	Baltin	nore, Ma	ryland 21	201	
St Regist	ate rar	31. Date filed (Month, Day, Year) FFB (14 2)	32. Pigistrar's Signature		of a					

			For State Registrar	State of Maryla		artment rtificate			and Me		jiene	200	5 03281
	Physici		1. Decedent's Name (First, Middle, Las	kenny					2	2. Date of Dea Month	th Day		3. Time of Death 8:20 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	1	1	of Death		0	County of Dea	th
	Funeral		Social Securify Number 6. S	ex 7. Age (In yr	s. last birthday)	If Under 1	Year Days	If Under 2	24 Hrs. 8	B. Date of Birth	1	9 Bir	thplace (State or Foreign
	Director		155-12-0884	PM 2□F 84	Yrs.	Worths	Days	Hours	\$6	(Month Day ept.10,	192	20 Ne	w Jersey
	Maryland 8-f show ilied at	tor	10a. State 10b. County MD Prince (City, Town or Lo	ocation							10d. Inside City Limits 1X Yes Z No
	th with the 23a or 28 at be not	Funeral Director	10e. Street and Number 6711 Park Hall Dr			10f. Zip C				1	log. Citiz	en of What Co	ountry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, Ire Magical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specific	y Cubar -	spanic Origin, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		4. Race - Ame Black, Whi Specify: Wh	te, etc.
1215-0	within 72 ho iene. • than "natur ir e Modical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2		(Give	dent's Usual kind of work DO NOT use ness M	done di retired)	uring most	of working	7		d of Business	/Industry
Maryland 21215-0036	2 should be filed and Mental Hygid Is marked other raumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Peter Charles Kenn		Dusi	ness r		18. Mothe	r's Name (First, Middle, i		Istar Sumame)	
Man	d 2 sho th and I t7 is me traume		19a. Informant's Name/Relationship (7) Florence Kenny / V	** *						Route Number			
re,	Pages 1 and in the pent of Health int: If item 27 iny or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	206	Place of Dispo cemetery, cre	sition (Name	e of	1	Da	-		cation - City or	
Baltimore,	rtmer rtent: njury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen) St	. Mary'				2/5/20 v Fled	005 ck Fune			Maryland
ä	Depa Impo any li once		ECA	SQUE.	14/	7601 S	Sand	y Spr	ing I	Road, L	aure		yland 20707
	Physician /Medical		23a. Part1. Enter the disease, or companies or companies. List only of the companies of the	A	E. bnllo							vespones	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consi	equence of):								
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a const	equence of):								
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)							23	23d. Date of delivery Month Day Year		
<u>α</u>	Se us	b	Part II. Other significent conditions of	ontributing to death but not r	esulting in the u	inderlying cau	use give	n in Part I.			bacco us	_	o the cause of death?
Vital Records,	The ate h	Completed	aut per							24a. Was a autops perform	prior to completion of cause of death?		completion of cause of
Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	□ ER/Outpation	nt 3□ DOA	Otho			Check on or		Cothes (See	
ion of	ding h. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5				d. Describe h			City)	
Division	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office 28f. L					If. Location (Si City or Town		Number or R	ural Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	ination and/or in	vestigation, in	n my on	inion, deat	th occurred	at the time, d	ate and i	place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	. 0	29c.	License	number	06	2	9d. Date	signed (Mont	th, Day, Year)
,	1100		30. Name and address of person who	completed cause of death (Ir	(M) tem 23a) (Type,	Print)	005	64	80		4	2/03	
	101'			evzingi Registrar's Sin	7500	Heno	rer	porteu	vay 1	(05)	green	bell-11	th, Day, Year)
	Sta Registr		FEB 0 4 200	5 Shows &	A Spar	w							

		for State	State	of Maryland		artment of H		nd Mental	Hygier	ne O O O E		
		Registrar 1. Decedent's Name (First, Middle	(ast)	····		tilicate of L	Jeam	2. Date of	Reg. I	y6. U U 5	3. Time of Death	
Physic		` i	KASP	FR				Month		Day Ye	ar	
/Med Exam		4a. Facility Name (If not institution				4b. City, Town, or	Location of			4c. County of D		
Adiii		GEnesis Multi	Medical	Conter		Towson				Balti	imoro	
Funera	1	5. Social Security Number	6. Sex	7. Age (In yrs. la.		If Under 1 Year Months Days	If Under 24 Hours		of Birth h, Day, Yea	Q	Birthplace (State or Foreign Country)	
Directo	r	219-18-0841	1 XM 2□ F	80	Yrs.		1100.0		3/192		Germany	
and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits	
Many -1 sh	jo	MD Polt	imoro	Do	II	-11					1 ☐ Yes 2 🔀 No	
13-UU30 72 hours after death with the Maryland 72 hours after death with the Maryland "natural", or items 23a or 28a-f show	Director	MD Balt 10e. Street and Number	imore	Pe	rry H	10f. Zip Code			10g. (Citizen of What	t Country?	
th with	aiD	9504-K Amberle	eigh Lane	2		21128				U.S.A.		
ems	Funerail	11. Marital Status		cedent Ever in U.S		Was Decedent of Hi If Yes, specify Cuba	spanic Origi	in? (Specify Yes of	or No-	14. Race - A	American Indian, Vhite, etc.	
OUSO hours after ural', or ite	by Fu	1 Never Married 2 Marri	ed 1 17 Yes	2 □ No iive		1 ☐ Yes 2 🔯 No	Specify:			Specify:	ville, etc.	
hours aftural, or		3 XWidowed 4 □ Divorced 15. Decedent	Year or	Dates: WW]	II	dent's Usual Occupa			1 405	the resume	White	
0 in 72	Completed	(Specify only highes	t grade completed		(Give	kind of work done o DO NOT use retired	furing most o	of working	160.	. Kind of Busine	ess/industry	
within jiene.	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Sol	f-Employe	a		17	a a manul a	s Delicatesser	
be filed tal Hyg d other	Be C	17. Father's Name (First, Middle, I	Last)			r-mproye	18. Mother	's Name (First, M	iddle, Maid	dSDEL S len Surname)	s Leticatesser	
Ytan ould be Mental varked o	ToE	Andrew Kasper					Anna	a Mell				
Mary d 2 sho th and l 7 is ma trauma		19a. Informant's Name/Relationsh				ng Address (Street a						
re, IV s 1 and f Health itam 27 other tr		John T. Jordan	(brother				Road					
00	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from	n State	metery, crei	esition (Name of matory or other place		Date			or Town, State	
altimor mit. Pages partment of portant: If it y injury or o		`4 □Donation 5 □Other (Sp		Hig							n, Maryland	
Baltimo permit. Pag Department Important: I any injury o		21. Signature of Funeral Service I) ,	, ,	10.000						cal Home, P.A.	
		23a Part 1 Enter the disease of	complications that	caused the death	no not on	750 Belai	r Road	d - King	svill	e, Mary	land 21087	
		shock, or heart failure. List only one cause on each line.								Interval Between		
Physiciar /Medica	_	disease or condition resulting in death)	a.			EPRES!	5100	V			DAYS	
Examine			Due to	(or as a conseque		217100	,				DAYS	
	e l	b. MALNUTRITION if any, leading to immediate b. Due to (or as a consequence of):								7 7 7		
uted d ansit	Examiner	causs. Enter Underlying Cause (Disease or injury that initiated events c.										
6U, be executed cian and burial-transit		resulting in death) Last	Due to	(or as a conseque	ence of):							
oaf fou, cate be executed physician and the burial-transit	dical		d									
antifica ing pl	Med	IF FEMALE:							=			
Geath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregnan birth 2 Fetal of	death 3[Ectopic pregnancy				23d. Date of Month	delivery Day Year	
at the de by the a	ysic	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)									ouy roan	
that the the the the the the the the the th	/Ph	Part II. Other significant condition	ns contributing to	death but not resul	ting in the u	nderlying cause give	en in Part I.	23e.	Did tobacc	o use contribut	e to the cause of death?	
0 8 8 0	d by					, ,					Probably 4 Unknown	
	Completed							242	Was an	24b Ward	a autonov findings available	
The la	Ę							_	autopsy performed1	? _ death	autopsy findings available to completion of cause of h?	
	a)	25. Was case referred to medical					26 Place	of Death (Check of		101	Yes 2□ No	
ysici ysici is cer direct	0	examiner? 1 ☐ Yes 2 Z No	Hospital:	Inpatient 2 E	R/Outpatier	nt 3□ DOA Othe		sing Home 5		6 □Other /S	Specify)	
1 OT 19 Phy 1er this 1eral d	n: T	27. Manner of Death		e of Injury nth, Day Year)	28b. Time o Injury		at			jury occurred	poorly)	
endir sath. or: Af	atic	1 Natural 5 Pending investig	jation	,,	,,		Yes 2□N	0				
UIVISION or Attending after death. Diractor: Afte	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 208. Place	ce of Injury - At hon ding, etc. (Specify)	ne, farm, sti	reet, factory, office			ion (Street r Town, St		r Rural Route Number,	
Dital of urs af												
UNISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica compiletely filled in by the funeral director.	edical	29a. Certifier Certifyin (Check only 2 Medical (one)	examiner: On the	basis of examination	rledge, deat on and/or in	h occurred at the tim vestigation, in my or	ie, date and pinion, death	place, and due to occurred at the t	the cause ime, date a	(s) and manne and place, and	r as stated. due to the cause(s)	
o the ithin 2 o the	Med	29b. Signature and title of certifier		nner stated.		29c. License	number		29d. I	Date signed (M	onth, Day, Year)	
F > F 8			1	N D				~~				
1		30. Name and address of person		YD	23a) (Type	Print)	> 513	> U	JF	71V 2 /	2003	
1671		SHAWNMA		UPTA P	O RO	x 6303	3 6	LLICOT	7 (CITYIY	7 2005	
· . S	tate	31. Date filed (Month, Day, Year)		Registrar's Signatu		,						
Regis	strar	FFB 0 4 20	05 Beat	in the	Loon							

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryland / Depa	artment of Health and M		ne No.2005	03283
			Decedent's Name (First, Middle, Las			2. Date of Death	110,000	3. Time of Death
	Physicia	an	Janice Mildre	•			Day Year 0, 2005	
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	10:30A [™]
	Examin	er						
	F		900 Lindellen Av 5. Social Security Number 6. Se		Reisterstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimor	
	Funeral Director		,	□M 2 X F 79 Yrs.	Months Days Hours Min.	(Month, Day, Ye		ace (State or Foreign ry) MD
			Usual Residence of Decedent	19		Feb. 8, 1	923	MD
	ylanc sow		10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	Man	ţō	MD Baltimo	re Reiste	ratoun			1 ☐ Yes 2∑ No
	28a	Director	10e. Street and Number	Reiste	10f. Zip Code	10g.	Citizen of What Count	ry?
	Sa or		900 Lindellen Ave		21126		USA	
	ours after death with the Marylar ral', or Itams 23a or 28a-f show Examinate out by mulfited at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	21136 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America	an Indian,
	ritar	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
ဗ္ဗ	al', o	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🖫 No Specify:		Specify:	ite
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Excirction institution at	Completed	15. Decedent's Ed	ucation 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Ind	
7.	nin 7. n n	pie	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) (Give life.	kind of work done during most of worki DO NOT use retired)	n <i>g</i>		
77	l withir liene. r than	E	12	, ,	om Operator		Lion Broth	ers
	be filed within 72 hc ital Hygiene. id othar than "natui evant, the Medical	BeC	17. Father's Name (First, Middle, Last)	,		(First, Middle, Maid		020
an	d be ental ked ked	To B	Benjamin Higgs		Cora Re	odor		
Maryland	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 la marked othar than othar traumatic evant, The M	-	19a, Informant's Name/Relationship (7	Type, Print) 19b. Maili	ng Address (Street and Number or Rura		ity or Town, State, Zip	Code)
E	P 5 5 5		Innian M Plymino	Doughton 000 i	Ideal-11 - In Poi	atoratorm	MD 21126	6
Ġ	1 and 2 Health tem 27		Janice M. Blymire 20a. Method of Disposition	20b. Place of Dispo	Lindellen Ave., Rei	Sterstown Date 200	Location - City or Tov	wn, State
altimore,	Pages nent of l int: If it		1 ☐ Burial 2 ⑦ Cremation 3 ☐	Hemoval from State	matory or other place)		2000	
井	rtmer rtant		'4 □Donation 5 □Other (Specify	- Julian	Cremation 2/1/	-	ampstead,	
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Service Licen	() - 1/ -	2. Name and Address of Facility		Reistersto	
	703 e 0		stephen IV	3	Eline Funeral Home		rstown, MD	
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	hysician	î u	Immediate Cause (Final disease or condition	· Cerebral V	ascular Ever	t		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		,		· Morning.
	Examiner		Conventingly, lies and distance	b				
		ner	Sequentially list conditions, if any, leading to immediate cause. Ent. U.J. J. Jr. ig Cause (Disease or injury	Due to (or as a consequence of):				
	od d	Examiner	Cause (Disease or injury that initiated events	C.				
o	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Exe	resulting in death) Last	Due to (or as a consequence of):				
8760	ate be ex hysician the buria	dicai		d				
68	ificat g phy as th	edi						_
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliver	y
B	seath atte	cia	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month	Day Year
o.	that the de ed by the detached	ıysi	1 □ Yes 2 🕱 No 9 □ Unknown	9□ Unknown				
4	res that the igned by be detact	P.	Part II. Other significant conditions of	ontributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
Records,	sign sign d be	d by	Previous certs	al vouslor event	1998	1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
Ö	w requir been si should	Completed	T.Curoso CC.O.			2. 146	Tau III	<i>C</i> - <i>C</i>
ec	has l	npi				24a. Was an autopsy	prior to con	sy findings available apletion of cause of
=		Co				performed 1 ☐ Yes 2 🗷	t? death? No 1 ☐ Yes	2□ No
Vital	Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?			(Check only one)		
=	Physic this o	2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 □ DOA Other: 4 □ Nursing Ho	me 5 KResidence	e 6 □Other (Specify)
Division of	ding P. After t		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how i	injury occurred	
Ö	uttandii death. ctor: Ai y the fu	atic	2 Accident investigation	1	M 1 Yes 2 No			
<u>\S</u>	ar de racte by t	tilling.	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural	Route Number,
	s aft s aft al Di ed in	Certification:						
	hour hour nare ly fill		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the caus	e(s) and manner as sta	ated.
	n 24 n 24 na Fu	Medical	(Check only 2 Medical Exan	niner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Ž	29b. Signature and title of certifier	01	29c. License number	29d.	Date signed (Month, L	Day, Year)
			1/2/1/1	Lymn	040223		1/31/05	
			30. Name and address of person who	completed cause of death (Item 23a) (Type			, (-)	
			Rebecca A. Goe		wood Trail, Hampte	ad MD 21	074	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	wood ITaII, Hample	au, FID 41	.0/4	
	Regist		FEB 0 4 200	5 Array M. Am	de			

			For State	State	of Marylan				Mental Hygic	- 201	15	03284
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)					Dealli	2. Date of Death	. No.		3. Time of Death
	Physici	an	FELIX				Month	Day 2005	Year	6:50 PM		
	/Medic		4a. Facility Name (If not institution	KARPUK	umber)		4b. City, Town, or	Location of Death		4c. County	of Death	10
	LXaiiiii	G	4309 SILVER	SPRING	ROAD	i		Y HALL			TIMO	ORE
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			place (State or Foreign
D	irector		217-42-7959	XXM 2□F		91 Yrs.	Widitins Days	Tiodis Main.	MAY 23,	1913		RAINE
and	M.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. fnside City Limits
Mary	faho	ō	MD. BAI	TIMORE		DERRY	HALL					1 ☐ Yes 2√2 No
the	7 28e	rec	10e. Street and Number			I DIVIVI	10f. Zip Code		100	g. Citizen of W	/hat Cour	ntry?
death with the Maryland	23a o	ai D	4309 SILVER	SPRING	ROAD		211	28		U.S.	Δ	
	ems :	Funeral Director	11. Marital Status		cedent Ever in U		Vas Decedent of H	ispanic Origin? (Si	pecify Yes or No-	14. Race		ean fndian,
s afte	or it	by Fu	1 Never Married 2 Mar	ned 1 ☐ Yes If Yes, G	ive XXNo	•	☐ Yes 2 No	Specify:	7 110411, 0(0.)	Specify		
within 72 hours after	tural al Ex		3 Widowed 4 Divorced	Year or l	Dates:	l 163 Docad	ant's Heurl Occup	ation			WHI	
72 ni	Apdic Apdic	Completed	(Specify only highe	st grade completed		(Give i	lent's Usual Occupa kind of work done o OO NOT use retired	during most of wor	king	6b. Kind of Bu	siness/inc	bustry
d with		mo:	Elementary/Secondary (0-12) 5	College	(1-4or 5+)	CABI	NETMAKE	R:		FURN	מוזייד) F
d be fife	vent,	Be C	17. Father's Name (First, Middle,	Last)					ne (First, Middle, Ma			
ould b	arked atic e	20	JACOB KARP	UK				PAULI		WIJCZ		
2 sho	ls m		19a. Informant's Name/Relations						ral Route Number, (
and and	or resum any weight any space of them 23a or 28e-f show tiem 21a or 28e-f show other traumatic event, the Modical Examinar most be notified at		ANNA KARPUK/	WIFE	20h E	4309	SILVER_ sition (Name of	SPRING	RD., PER	RY HA	LL,M	D. 21128
Pages '	nent of H int: if ite iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation			emetery, crem	natory or other plac	' I		oc. Location	-	
it. Pa	문문를		' 4 □ Donation 5 □ Other (S	·	ST.		'S BRYA Name and Addres		2/5/05 B	RYANT	, NWC	MARYLAND
D E S	any ir		- Continue		Sie de	// L	ILLY &	ZEILER	INC. FU	NERAL	НОМ	E
1	6011		23a. Part1. Enter the disease, or	complications that	caused the deat	h. Do not ente	or the mode of dyin	g, such as cardiac	or respiratory arres	r.T.T.W()]	RE, M	D. 21231 Approximate
Phy	/sician										Interval Between Onset and Death	
/N	ledical		resulting in death)	aDue tf	(or as a conseq	uence of):		2112	+12		-/	TVE GEARS
Exa	aminer		Sequentially list conditions	b. 01	ASET	211	MELLI	TUS	. '		1	1411 17 4841
D	ŧ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uente of):						1, -
ecute	and I-tran	Examin	that initiated events resulting in death) Last	uence of):								
orou, ate be execuí	physicien and the burial-transit	aiE			(
	phys	edicai		d								
The law requires that the death certific	been signed by the attending i should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	ancy	F-1			23d. Date	of delive	ну
deat 0	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)			Mor	ith	Day Year
. ta	by the	Phys	9 ☐ Unknown									
es t	pe q	by	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the un	derlying cause give	en in Part I.				ne cause of death?
inger inger	pluor	ted	()CIAS MIC	A1)11	0440	1414	9		1 🗆 Yes	2 (No	3 🗌 Prob	ably 4 □Unknown
necords,	S C1	Completed	CONGESTI	VE 14	EARI	PAI	LVKE		24a. Was an autopsy	P	rior to cor	psy findings available in pletion of cause of
	icate r. pag		114 PERTE	NJION	/				performe 1 Yes 2		eath? Yes	2 No
VICAL sician: T	s certificate has b lirector, page 2 s	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital:	Name to a C	ED/0	Othe	0.5	th (Check only one)		-	
o F	ar this aral d	-	27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	28c. Injury	/ at	ome 5 Resident			//
VISION Attending	r: Aft	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day Year)	fn _f ury	Work M 1 □ '	Yes 2 □ No				
VIS r Atte	recto by th	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 289. Plac	e of fnjury - At he		et, factory, office		28f. Location (Stre City or Town,		r or Rura	l Route Number,
itel 2	rei Di											
UNIVISION OF VICAL To the Hospital or Attending Physician:	withing a founds after to be after this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical	Examiner: On the	basis of examina	wiedge, death ition and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	, and due to the cau rred at the time, date	se(s) and mar e and place, a	ner as st nd due to	ated. the cause(s)
o the	o the	Med	one) 29b. Signature and title of certifie		nner stated.		29c. License	number	290	I. Date signed	(Month.	Day, Year)
F 3	s ⊢ ŏ		V ques	1. The	MAN	n	034			501719		
	Λ		30. Name and address of person			n 23a) (Type, I	Print)				- 1	
	2		5601 Loc	it KAVE	NBL	V). BK	HITIM	018, M	2-216	239		
	Sta	- 1	31. Date filed (Month, Day, Year)	1 2005 32.	egistrar's Signa	iture				j		
	Registr	ar	1 bc (J (± 2005	tiens s	5. G	WE					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Haja-Safiatu Dyfan Lyoubi 3:33 AM DANDAY 30, 2.005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F N/A 74 Director 01/15/1931 <u>Sierra Leone</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at MA Norfolk Norfolk Director ¥ Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 Miller Street 02056 Sierra Leone Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 20XNo 1 Never Married 2 Married Yes Specify: Black Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Completed by ₩Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within in and Mental Hygiene.
7 Is markad other than " College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ismail Dyfan Nana Conteh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is 1 Abdul Sesay / Son In-Law 47 Miller Street MA 02056 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any Injury or once. Knollwood Memorial Park 2/4/05 ` 4 ☐ Donation 5 ☐ Other (Specify) Canton 21. Signature of Funera) Service Licensee Tom Zizos Charles L. Stevens Funeral Home 1501 Hast Fort Ave Baltimore Mo d 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shoc **Physician** C disease or condition resulting in death) /Medical Due 4 (or s a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit hrom'c that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Bunknown 1 Yes 2 No 3 Probably this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perfoc neumon 1 Yes 1 Tes 2 🗆 No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 3 EXMO Other: Certification: To 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28 Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funaral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 285 Rinso Name and address of person to completed cause of death (Item 23a) (Type, Print 344 UmVersi 32 Registrar's Signature 31 Date filed (Month B 0 4 State 2005 Registrar

		1 - For State Registrar	tate of Maryland / Dep <i>Ce</i>	eartment of Health ar e <i>rtificate of Death</i>	nd Mental Hygien Rag. N	71115 113296
		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physic /Medi		ELZANOR	M. LAMBE	.दा	JANUARY:	ay 2005 11:30 A M
Exami	ner	4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Location of	Death 4	c. County of Death
. Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24		9. Birthplace (State or Foreign
Director		MOI 1014 HIGH 416	250 F 82 Yrs.	Months Days Hours	Min. (Month, Day, Year)	23 GOUNTY) LYANIA
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
Maryli f sho	ō	MARILAND EARROLL	SYKS			1 ☐ Yes 2 No
h the	Director	10e. Street and Number	3/10	10f. Zip Code	10g. C	itizen of What Country?
death with the Maryland ms 23c or 28e-f show	aiD	7111 CORRES Y	AVI.	21784		V.S.A.
13-UU30 n 72 hours after death with the Marylar "natural", or Items 23s or 28e-1 show offset Executive to any be multified at	Funerai	Tr. Marian Glass	Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	 Race - American Indian, Black, White, etc.
72 hours after natural; or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 250 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 114
72 hor	eted	15. Decedent's Educat (Specify only highest grade of	on 16a. Dec	edent's Usual Occupation e kind of work done during most of	of working	Kind of Business/Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		A 11
filed within I Hygiene.	e Co	17. Father's Name (First, Middle, Last)	3/6	18. Mother's	s Name (First, Middle, Maide	on Sumame)
ld be lental rked c	To B	CHARIST HERE	RY MILLER	723	ZUZ MARIZ	ADAM
iaryiar 2 should be and Menta is marked aumatic ev	_	19a. Informant's Name/Relationship (Type,		ling Address (Street and Number		
lore, Maryiano Z.I.Z. ges 1 and 2 should be filed withi 1 of Health and Mental Hygiene. If liem 27 is marked other than or other traumatic event. ILEM		SARORA MARIE LIL	20b. Place of Disp	MORRA AVE S	Date Oc. I	Hare onellan
Pages 1 nent of H int: If ite	-	20a. Method of Disposition 15 Burial 2 Cremation 3 Rem	oval from State	ematory or other place)	40-30	Location - City or Town, State
글 고등문능 .		*4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee	1 Dest A	0 1 2 1 1 1 1 1 1 1 1 1	Acos TA	KANTIS I LAWITAVO
Depa Impo Impo any ir		1000	2	22. Name and Address of Facility とくない。テンクなでれた そろう ガヤイトンベル	KOGI LUKKNI	TERE CHATENOUS 1 SEE
		23a. Part1. Enter the disease, or complicit shock, or heart failure. List only one	lons that caused the death. Do not en	nter the mode of dying, such as ca	ardiac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ASPIRATION	MEUMONIA	4	Onset and Death
Examiner		f	Due to (or as a consequence of):	RUNE C.	V. A.	
	Je .	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
and transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
reate be executed physician and sthe burial-transit		resulting in death, East				
	edicai	d				
COIGS, P.O. BOX to wrequires that the death certifues igned by the attending should be detached for use a	an/M	23b. was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
O. DO ne death the atten hed for u	Physician/M	in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown		Other (specify)		Month Day Year
Ords, P.O. requires that the een signed by th nould be detache	/Ph	Part II. Other significant conditions contril	outing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rdS, quires on sign	ed by	TYPE Z DIAGOI	Meural		1 ☐ Yes 2	2 No 3 Probably 4 Unknown
TECOTO e law requir has been si je 2 should	Completed	HYPETENNO			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ate pag	Com	Peurusy Mu	in Dilane.		performed? 1 ☐ Yes 2 🔀 N	death?
OT VIXAL Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital: 1 Innetion 2	Oth	of Death (Check only one)	
on or of the control	1: To	10 163 225 110	28a. Date of Injury 28b. Time	of 28c. Injury at	sing Home 5 Residence 28d. Describe how inju	
ath. r: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	0	
UNISION or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	 Place of Injury - At home, farm, s building, etc. (Specify) 	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
poltal ours al		29a. Certifier 154 Certifying Physic	an: To the best of my knowledge, dea	ith occurred at the time, date and	place, and due to the cause/	s) and manner as stated
DIVISION OF To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		: On the basis of examination and/or i and manner stated.			
To the comp	ž	29b. Signature and title of certifier	V	29c. License number		ate signed (Month, Day, Year)
		Church M.	Jun	D C0036	JA JA	MARI 28, 2005
1		30. Name and address of person who come	plated cause of death (Item 23a) (Type KE MD 6761	N: CHARLES S	ST #YICK PA	470 ND 212NA
St	ate	31. Date filed (Month, Day Year)	32. Registrate Signature 2005	2 1	,	
Regis	trar	FED V 4	LUUS JARRENE D	Poster		_

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		•	For State of Maryland / [Department of Health and N Certificate of Death	Mental Hygier	/1115	03288
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		GRACE B. MATUKATTIS			29 2005	BILZ PM
	/Medic Examin		ta. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			AUGSBURG LUTHERAN HOME	BALTIMORE			
	Funeral Director		188-10-1,109	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea	1933 PENG	hplace (State or Foreign untry) VAN
	and w	}	Usual Residence of Decedent 10c. City, Tow 10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
	Maryl f sho	Į,	Tarilan BALTIMORE PER	WHOM			1 ☐ Yes 2 No
	r 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	untry?
	h with	al D	9518 ARRY HALL BLVD. AFT 363	21234		- A 2.41	
	ems a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White	
36	or it	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	,	Specify:	1>-
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show acal Examiner must be notilied at	ed by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a.	Decedent's Usual Occupation	16h	Kind of Business/	MIT2
21215-0036	y within 72 hours after death with the Marylan jiene, rtan, "natural", or liems 23a or 28a-f show the Modical Examiner must be notified at	Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king GA	13500 Th	COROL KANGE
212	d within piene. r than "	E O	Elementary/Secondary (0-12) College (1-4or 5+)	AFETERIA WORKER		= SOUCAT	-
b	be filed ital Hygi od other event, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	
/lar	should be nd Mental nmarked c	To E	CALVIN 2 BRURY	hotti	E SONOE	3	
Maryland	2 sh and is m	gr (0.0	. Mailing Address (Street and Number or Ru		~	Tip Code) 21009
	1 and Health em 27 other tr	1 9	OANO C. VIATA KAITA 20a. Method of Disposition 20b. Place o	505 W 000 (5 (100 K No V	RT AGIN	Location - City or	Town State
סר	00		12 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemete	ry, crematory or other place)	a. 0	Cocation on or	la coll e
Baltimore,			14 □ Donation 5 □ Other (Specify) 21. Signal 1 (Fu on Server Licentee	WOO LINEUM 20	JEWO GIE	Kritte 1	1441 TEVO
Ba	permit. Departr Imports any Inj		Trop Was	SECO HARDER RO	AD PARKY	is MARY	
П			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	,	Approximate Interval Between Onset and Death
	Pnysician /Medical	3 4	Immediate Cause (Final disease or condition resulting in death)				
	Examiner		Due to (or as a consequence	of):			
		ie.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
V	outed nd ransit	Examiner	that initiated events				
0,	The faw requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence	of):			
8760,	ohysic the b	Physician/Medical	d				
9 x	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	ivon
Вох	eath certific attending p	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Month	Day Year
o.	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
۵,	igned k	by P	Part II. Other significent conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ığ	w require been sig should b				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Vital Records,	e law re has be je 2 sh	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>		Con			performed	? death? No 1 \(\sum \text{Yes}\)	2 🗆 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)		
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on	Attending F r death. sctor: After by the funer	tlon		Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, Str		ıral Route Number,
	spitel or Atten ours after deat lerel Director: filled in by the	Certification:	Tomoras Building, etc. (openny)				
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in the form of the filled in the form of the filled in the	Medical	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge 2 Medical Exeminer: On the basis of examination are and manner stated.	e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month	h, Day, Year)
•			Raymond Wille MIS	D47683	FIR	CUARY 1	2005
	3		29b. Signature and title of certifier Waymond Molly Mills 30. Name and address of person who completed cause of death (Item 23a) Raymond Mills 25 Man Sivur Sur 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature FEB 0 4 2005	(Type, Print) Le 200 Rey Krabon A	∿D		\
	Sta		31. Date filed (Month, Day, Yeer) 32. Registrar's Signature	Arasto !			
	Registi	rar	FEB 0 4 2005 Slower 2	Sympa			

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		-	For State Registrar	•	partment of Health and I	Mental Hygien	4000	03289
	* %		Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		2. Date of Death	-	3. Time of Death
	Physicia /Medic		MARIE ANNA P	1.TCHTLL		JAN. 30	2005	7:44P.M
	Examin		4a. Facility Name (If not institution, give stre	eet and number)	4b. City, Town, or Location of Death	1 4	c. County of Deat	h
			CARROLL Co G	TENTRAL	WESTMINS	IER	CNER	٥٠٠
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd.	Months Davs Hours Min.	8. Date of Birth Month, Day, Yea	9. Bin	hplace (State or Foreign buntry)
	p .		Usual Residence of Decedent					101111111111111111111111111111111111111
	anylar show	_	10a. State 10b. County	10c. City, Town or	~			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	8e-f.	cto	MID CARRO	LL FINKS				
	or 2	Dire	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Co	ountry?
	s 23s	ral	1508 MARIE	CI.			14. Race - Ame	rican Indian
	er de	Funeral Director	11. Marital Status 12 1 □ Never Married 2 □ Married	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	
	s i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I fleating a 33 or 28e-f show filem 21 is marked other than "natureli, or items 23a or 28e-f show other traumetic event, it is Madisal East in arritual be indiffed at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 200 No Specify:		Specify: \	JULIE:
5	2 ho	ted	15. Decedent's Educa (Specify only highest grade of		ecedent's Usual Occupation ive kind of work done during most of work	16b.	Kind of Business/	Industry
7	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)			11.
7	ygien ygien ser th	Completed	6	ile	WE NIVE	<	<u> </u>	FRME
	ild be filed with lental Hygiene. ked other that ic event, the	Be	17. Father's Name (First, Middle, Last)	-OU ROW	18. Mother's Nan	ne (First, Middle, Maide	in Sumame)	inda
2	should be ind Mental inmerked of umetic evi	2	19a. Informant's Name/Relationship (Type	Print) 10h M	ailing Address (Street and Number or Ru	Ural Boute Number City	or Town State	Zin Code) 3.000
	d 2 s		^	TCHTLL/SON 15	08 MARIE (The Land of the La	Rich	E MOZIGIE
ש	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra		20a. Method of Disposition	20b. Place of Di	sposition (Name of	Date 20c.	Location - City or	Town, State
ранишо	Pages nent of ant: If it ary or o		1 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	crematory or other place)	1/2005 2	NPRO	TM
	artme orter injur		21. Signature Funeral Service Licensee	0,41)	22. Name and Address of Facility	MES CALL	TE OF 1	MEMORIES
Ď	permit. Departr Importe any inju		MOH	- MO1720	8800 HARFORS	R Pre	KULLE 1	ND 21234
- 4	y - 1		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
火網	Physician		Immediate Cause (Final disease or condition	ASTUD				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):				
	Examiner		Sequentially list conditions, b.					
T	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
J	and and III-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
00/	death certificate be executed e attending physician and id for use as the burial-transit	icalE						
00	flicate g phy: as the		Q					,
XOD	n cert andin	Z	IF FEMALE: 23b. Was decedent pregnant 23c	If yes, outcome of pregnancy	3 □Ectopic pregnancy		23d. Date of del	,
0	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2: 12 No	4 Pregnant at time of death	5 Other (specify)		Month	Day Year
Э	at the 1 by tf etach	Phy	9 Unknown			OD- Biddebase		4h
Š,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	þ	Part II. Other significent conditions contri	buting to death but not resulting in th	e underlying cause given in Part I.	1 Yes		o the cause of death?
cords	requi	Completed					1	
ec	e law has t je 2 s	ld m				24a. Was an autopsy perform#d?	prior to	stopsy findings available completion of cause of
	n: The l licate ha					1 ☐ Yes 2 🔼 1		2 No
=	sicien	o Be	25. Was case referred to medical examiner?	spital: A Spital	Other	ath (Check only one)	A [] Out / Out	
ō	Physic rithis oral di	-	1 ☐ Yes 2. No 27. Manner of Death	28a. Date of Injury 28b. Tim	e of 28c. Injury at	lome 5 Residence		city)
0	ath. :: Afte	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No			
IVISION	Atter	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta		ural Route Number,
5	telor rsafte nal Dir	Certification:	4 Trombide	building, etc. (appeary)		0.17 0.1 101111, 0.10		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical			eath occurred at the time, date and place or investigation, in my opinion, death occurrences			
	within To the compl	Me	29b. Signature and title of certifier	111-	29c. License number	29d. [Date signed (Mont	h, Day, Year)
			I Comman II	allten	12658	5 1	-31-1	05
	10		30. Name and address of person who com	pleted cause of death (Item 23a) (Ty	pe. Print) ten Heights Mod. (00 101		14.0
	l T		DRGoldstein o	218 Washing	ton Heights Med (IR, WIS	thingte	1/10
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 4 2	005 Reg fran's Signature	Aposes			

		•	For State Registrar	State of Ma	aryland / I	Departme <i>Certifica</i>			nd Mental	Hygie Reg.	C U	05	03290
	°Physicia	an.	1. Decedent's Name (First, Middle, Last)						2. Date of	1	Day .	Year	3. Time of Death
	/Medic		Alejandro Meji			45 0	h. Tourn	-1	Febr	uary	10 Cour	2005 nty of Death	5:15 AM
	Examin	er	4a. Facility Name (If not institution, give s	d the car	ο,	40. CI	-	r Location of 1 HMOY		ď	4c. Coul	nly or Death	
× .	Funeral	*	5. Social Security Number 6. Sex	7. Ag	e (In yrs. last bi		der 1 Year	If Under 24		of Birth	arl	9. Birthp	lace (State or Foreign
	Director		217 30 3233 2	M 2□F	71	Yrs. Month	s Days	Hours	APR •	8, 1	933	1	a, Colombia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location	-					1	0d. Inside City Limits
	Maryl:	io	MD Howard		Ellic	ott Cit	У						1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number		1	10f.	Zip Code			10g.	Citizen	of What Coun	ntry?
	th with	Funeral Director	11905 Triadelphia	a Road			2104	2			US	A	
	ar dea tams	nuel		12. Was Decedent Armed Forces?		13. Was De If Yes, s	cedent of H pecify Cuba	lispanic Origir an, Mexican, I	n? (Specify Yes o Puerto Rican, etc	or No-		lace - Americ lack, White,	
36	irs afte	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ ↑ If Yes, Give Year or Dates:	No	1 🌠 Yes	2 🗆 No	Specify:			Spe	cify: Colo	mbian
9-0-	2 hou	ted	15. Decedent's Edu	cation	16a	. Decedent's U	sual Occup	ation	of working	161	o. Kind of	Business/Ind	dustry
215	thin 7 e. lan "n	nple	(Specify only highest grade	College (1-4or 5	5+)	(Give kind of life. DO NO)	use retired	d)	n working				
21	led wi lygien her th	Con	12	7		Medica	1 Doc		s Name (First, M			h Care	2
and	ibe fi ntal H ad oti	To Be Completed	17. Father's Name (First, Middle, Last) Luis A. Mejia						F. Meji		Jen Jun	ame)	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Itams 23c or 28a-1 ahow Imatic avant, I're Medical Evarrither rest by rolliked at	ř	19a. Informant's Name/Relationship (Ty	pe, Print)	198	o. Mailing Addre	ess (Street		or Rural Route N		ity or Tov	vn, State, Zip	Code)
	and 2 : ealth ar n 27 is		Shirley A. Mejia	- wife	1.	1905 Tr	iadel	phia R	d., Elli	cott	Cit	y, MD.	21042
Jre,	as 1 a of Hec of Hism litam rotha		20a. Method of Disposition	amount from State	20b. Place o	of Disposition (f	Name of or other plac	ce)	Date	200	. Locatio	n - City or To	own, State
altimore,	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 【XCremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	Balti	more Wa			-04-2005			1, MD	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If itam 27 is marked other than "natural", or Itams 23s or 28a-1 ahow any injury or other traumatic avant, the Medical Evantive frankle or configuration.		21. Signature of Funeral Service License	idem	an	22. Name Gary 7250	^{and Addre} L• Ka Washi	ss of Facility ufman ngton	Funeral Blvd., B	Home Elkri	@Me dge,	adowri MD 2	dge MP, Inc. 21075
	m •		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused ne cause on each li	the death. Do	not enter the m	of e of dyin)	ory arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Blot	0000	tu d	un	_ 00	me			ż	2000
	/Medical Examiner		Todaming in doziny	Due to (or as	a consequence	of):	U						•
1		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):						-	
	cuted od ransit	Examiner	that initiated events	2									
,0	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
8760,	physic physic s the b	dica		1									
Box 6	The law requires that the death certificate be execuled ate has been signed by the attending physician and page 2 should be detached for use as the burial-transli	ompleted by Physician/Medical	IF FEMALE:	3c. If yes, outcome	of pregnancy						23d.	Date of delive	erv
B	death ie atter ad for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at	2 Fetal death time of death	h 3 □Ectopia 5 □ Other		у				Month	Day Year
.Ω o.	at the de by the a tached	hys	9 Unknown	9□ Unknown							The state of the s		
3) 's	es thal igned t be det	by F	Part II. Other significant conditions con	ntributing to death b	ut not resulting	in the underlyin	g cause giv	ven in Part I.					ne cause of death?
ML ecords,	w requir been si should	eted	myygfre Hon	11-0-1	7 4000	- rece	an,			-	2 🗆 No		ably 4 Unknown
	e law has b	nple	Clark John	m) 1	reum	Suca				Was an autopsy performed	1	 b. Were auto prior to cor death? 	psy findings available mpletion of cause of
$\frac{a}{R}$		O	0						1 🗆 🕽	es 25		1 ☐ Yes	2 No
drc Vital	Phyaician: this certificant all director,	o Be	25. Was case referred to medical examiner?	lospital:	ent 2 □ EB/O	utpatient 3	DOA Ott		of Death (Check of Sing Home 5 🗌		e 6∏0	Other (Specifi	v)
andr n of Vita	g Phy er this neral c	n; To	27. Manner of Death	28a. Date of Inju	iry 28b.	Time of Injury	28c. Injui	ry at	28d. Desc				,,
. <u> </u>	anding Feath. or: After he funer	atlo	1 Natural 5 Pending investigation	(17157131)	,	M		Yes 2 □ No	0				
A / 6	or Att fter de jiract n by t	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, f c. (Specify)	arm, street, fac	tory, office			ion <i>(Str</i> ee or Town, S		mber or Rura	al Route Number,
	pital	0	29a. Certifier 1 Certifying Phy	picies: To the heet	of my knowledg	se death occur	od at the ti	me date and	place, and due to	the caus	e(s) and	manner as st	tated
	To the Hospital or Attanding P. within 24 hours after death. To the Funeral Diractor: After to completely filled in by the funera.	edical	(Check only one)		f examination a								
	To th within To th	Me	29b. Signature and title of certifier	1 0			29c. Licens	se number	-)			ned (Month,	
			POUNT()	Kans			1	775			2-	1-0	7
4	13		30. Name and address of person who co	ompleted sause of o	death (Item 23a)	(Type, Print)	Melle	lens	2172	8			
Ì	Sta Regist	ate	31. Date filed (Month, Day, Year), FEB 0 4 20	32. Registr	ar's Signature	Apart				,	-		
	riegist	reit	A CHING AND	49"		20,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** ľУм Robert George McLane, Sr. 2:42 January 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 951 Lombardee Circle Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 11 XM 2□ F Director 212-34-5487 66 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Experiment 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 951 Lombardee Circle 21061 **USA** Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ^{2□No} NAVY 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1965–67 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Letter Carrier United States Post Off. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Francis McLane Helen Marie Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen McLane - wife 951 Lombardee Circle, Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21075 Meadowridge Mem. Pk. | 2/03/2005 Elkridge, MD 22. Name and Address of Facility Cary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Funeral Service Licenses 17250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Entrol e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ad by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown es Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1 Yes 2 or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 70 2 ER/Outpatient 3 DOA 4 Nursing Home in by the funeral dir Hesidence 6 ☐ Other (Specify) this 27. Manner of Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Pescribe how injury occurred Certification: 5 Pending investigation 1 TYes 2 □ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifier 2005

Registrar DHMH 17 Rev 1/2001

State

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Division of Vital Records, P.O. Box 68760,

U ~

063

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

V

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2-005 JUDY LUCILLE MURPHY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Franklin Rosedon t t058 to Squal 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs Director DEC 1. INDIANA 306.32.9429 Usual Residence of Decedent XX the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic avant, the Medical Examinar must be notified at 1 XXes 2 □ No Director WABASH WABASH IN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1941 VERNON ST. 46992 USA APT 1 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ★ Ko
If Yes, Give
Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: ₩₩Widowed 4 Divorced δ WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION WORKER AUTOMOTIVE unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F CARRIE MARIE CRUMRINE EARL SUMMERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any in ury or othar traum once. 1005 OTTER POINT RD. ABINGDON, MD JANE JONES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State FEB 7,2005 MARION, IN GARDENS OF MEMORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CRECORY FINE MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part Enter the disease, of shock or heart failure. Lis Approximate Interval Between Onset and Death of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner da the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 🗆 No 1Z Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☑ Yes 2 ☐ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To tha To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Kb, 01,2005 Eddd EC and address of person who completed cause of death (Item 23a) (Type, Print) Balt or stuart wi 9000 Franklin 10M1 3. Registrar's Signature 31. Date filod (Month, Day, Year) State Registrar FEB 0 4 2005

State of Maryland / Department of Health and Mental Hygiene 03293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Elizabeth McSorley **Physician** Anne February 2005 2:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse Assisted Living Baltimore Pikesville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 377-12-3722 1 □ M 2 TF 83 Sept 7 Director WV Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural" or the financial or the financia 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore Pikesville 1 ☐ Yes 2√☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 8911 Reisterstown Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No f Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) real estate 12 realtor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John McSorley Anna Kennedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara A. Morris (personal rep) 2 Schneider Dr., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) All County Cremation 2-3-05 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

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TO STATIC CONTROLL CONTROL Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 pronths? 1 ☐ Yes 12 ☐ No 9 ☐ Unknown Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2/ No 1 🗌 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manager of Death or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number sullu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHANI 7220 ASNE em 32. Registrar's Signature 31. Date filed (Month State Registrar

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			30. Name, and address of person who	completed cause of di	eath (Item 23a) (Type	Print)	24	7	Junay	Month, Day, Year) 1, 2005	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GOOVE ANL harles /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAMARITAN BALTIMORE
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days Months Hours 1**∑**M 2□F 216-54-0614 55 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be mutified at Baltimore 1 Yes 2 No Director Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21239 permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Items 23a only injury or other traumatic event Marble U.S.A. 4641 tall Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: þ Spacity: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melui' 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Ball 21215 Isi'a 2702 bea Keyworth 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11 2005 22 Name and Address of Facility 21. Signature of Funeral Service Licensee les Funeral Service P.A. 1701 Mc Cullah 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEVERE PNEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? SUBSTANCE ABUSE 2 🗆 No 2 2 No 1 Yes Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 □Inpatient 2 □ ER/Outpatient Other: 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Man or of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State of Maryland / Department of Health and Mental Hygiene

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	•	For State Registrar	(epartment of Health and Certificate of Death	Reg	. No. 2 0 0 5	0329
Physicia /Medic		1. Decedent's Name (First, Middle, Las Michele Noble Mo	cKinley			29,2005°°	3. Time of Death 5:15 A
Examin	er	4a. Facility Name (If not institution, give 7157 Morning Li		4b. City, Town, or Location of Deat Columbia	h	4c. County of Death Howard	
Funeral Director			7. Age (In yrs. last birthe	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 25,	(ear) 9. Birthp Count 1956 Mary	lace (State or Fore try) land
-f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. City, Town o			1	0d. Inside City Lim
or 28a De noti	Direc	10e. Street and Number		10f. Zip Code		. Citizen of What Coun	
nust	eral	7157 Morning Light		21044		nited Stat	
to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XX o If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 KKNo Specify: 	o Rican, etc.)	Black, White,	etc.
e natur Medical	npleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)	rking	b. Kind of Business/Ind	lustry
Hygier other th ent, the		12 17. Father's Name (First, Middle, Last)	4 Tea	cher 19 Mothoda Nor	ne (First, Middle, Ma	ducation	
ed of	Be c	Sheldon Noble			a Gerst	iden Sumame)	
h and Mental Hygiene. 7 is marked other than traumatic event, the Market	ပ္	19a. informant's Name/Relationship (7		Mailing Address (Street and Number or Ru 57 Morning Light Ti	ıral Route Number, C		
Heall tem 2 other		20a. Method of Disposition	20b. Place of D	isposition (Name of		c. Location - City or To	
nt: If i		t Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Judean	Memorial Gardens	1/31/05 0	lney, MD	
Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Ocean	S88	22. Name and Address of Facility Ha		neral Home	, P.A.
Medical xamine transit and to rise as the burial-transit and to rise as the burial-transit and the rise as the burial-transit and the rise are the burial-transit and the rise are the province and the rise are the rise and the rise are the	i Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Final II defining Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of) b. Due to (or as a consequence of) c. Due to (or as a consequence of)	:			Onset and Deat
physic the b	dicai		d				
ate has been signed by the attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
n signed b	by	Part II. Other significant conditions of	ontributing to death but not resulting in t	ne underlying cause given in Part I.		cco use contribute to th	
ate has been si page 2 should	Completed				24a. Was an autopsy performe 1 ☐ Yes 2 ∑	prior to con	osy findings availanted and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second a
certificate rector, pag	Be	25. Was case referred to medical examiner?	16		ath (Check only one)		
this c	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	lome 5 XF esidence 28d. Describe how	e 6 Other (Specify injury occurred)
After funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,
After funer	e			death occurred at the time, date and place			
n 24 hours after death. le Funeral Director: After letely filled in by the funeral			niner: On the basis of examination and/ and manner stated.	January opinion, assure social			
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical Cert	(Check only 2 Medical Exam	and manner stated.	29c. License number		. Date signed (Month, I	Day, Year)
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral programmes.	edical	(Check only 2 ☐ Medical Examone) 29b. Signature and title of € stiffer	and manner stated.	29c. License number	JA	NUARY 29,	Day, Year)

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			iene .g. 2005	03298
	Physici /Medic	cal	Decedent's Name (First, Middle, Samue) 4a. Facility Name (If not institution,	Mccord		4b. City. Town. o	r Location of Deatl	2. Date of Deal Month	Day 3 Year 4c. County of Death	3. Time of Death
	Funeral Director	ler	FUTURE CARE 5. Social Security Number 214-03-2028	- CANTON	HARBOR e (In yrs. last birthday 92 Yrs.	BALTI		MD	BALTIMO	ne city place (State or Foreign yland
	72 hours after death with the Maryland netural', or Items 23a or 28e-f show Jigel Exam at must be rediffed at	Director	Usual Residence of Decedent 10a. State 10b. County Md. Carr 10e. Street and Number	o11	10c. City, Town or L	rstown				10d. Inside City Limits
	ath with	rai Dir	2351 Elderberry				136		0g. Citizen of What Cou	ntry?
9036	within 72 hours after death with the Marylan liene. r then "netural", or Items 23a or 28e-f show Un Medical Exarti no must be modified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Yes 2224 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
Maryland 21215-0036	within lene. then "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8		(Give	dent's Usual Occup kind of work done o DO NOT use retired hanic	during most of wor	king	16b. Kind of Business/In	
/land	should be filed nd Mental Hygi marked other imetic event, I	To Be (17. Father's Name (First, Middle, L Samuel H. McC					ne (First, Middle, A ne Schulz		
	ges 1 and 2 should it of Health and Men if item 27 Is marke or other treumetic		19a. Informant's Name/Relationshi Jane McCord / D		19b. Maili 2351	ng Address (Street Elderber	and Number or Ru ry Lane,	Reisters	City or Town, State, Zip	21136
Baltimore,	Pages 1 and the sent: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Sp.		20b. Place of Disponsion Commetery, creametery, creameters	matory or other plac	2-5		Rossville,	
Balt	permit. Page Department (Importent: If eny injury or		21. Signature of Funeral Service L	x XIQC	2	134 W+110	w Spring	Rd Ro	neral Home,	Inc.
	Pnysician /Medical	6 1	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	KSPIN	ation Pha	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any terms of the cause. Enter Underlying Cause (Disease or injury	b. Due to for s	a consequence of):		_		-	
8760,	cate be executed oblysician and the burial-transit	ical Examine	Cause (Disease or Injury that initiated events resulting in death) Last		a consequence of):					
.O. Box 6	death certifii e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant condition Atnal F	s contributing to death be brilla hov		nderlying cause give	en in Part I.		acco use contribute to the	_
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o	ting Physicien n. After this certifi funeral director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investiga	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 28b. Time o	28c. Injury Work	ar: 4 Thursing Ho	th (Check only one	nce 6 Other (Specify	
Division	Hospitel or Attendi 44 hours after death. Funerel Director: A tely filled in by the f	Certification;	3 Suicide 6 Could no determin	t be	rry - At home, farm, str c. (Specify)			28f. Location (Str. City or Town,	eet and Number or Rura State)	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Direction completely filled in I	edical	29a. Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	examination and/or in	vestigation, in my op	inion, death occur	red at the time, da	te and place, and due to	the cause(s)
)	To the To the complet	Σ	29b. Signature and title of certifier	Mal		HOO	61312	29	d. Daye signed (Month, I 31/05) D, GLEN BU	Day, Year)
	5		30. Name and address of person w	SHAH	Path (Item 23a) (Type,	Print) URNANCE	BRANC	H ROA	D GLEN BU	CNIE 21060
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 0 4	2005 32. egistra	irs Signature	nodi			,	

	inda Lo		se Nicotera-Butler Please	Type or Print	in Blaci	k Indelible Ink	Ensure Al	I Conies	s Ar	a Legible	
	ern		1- State Unpend Item 2	State of Man 3a,27,28a-f	/land/C	epartment of L G840 2-17 Certificate of	lealth and M -05 tas Death	lental Hy	/gier	ne •2005	03290
	Physic		Decedent's Name (First, Middle, Lass Linda Louise Nicot					2. Date of D Month		9, 2005	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	Januar		9, 2005 Ic. County of Death] 2:20 A M
V)			3211 Guilford				1timore			N/A	
Ş.	Funeral Director		Social Security Number UNK Social Security Number UNK	M 250 F 5	n yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 12/05	irth ay, Yea 5/19	9. Birth Co. 48 MD	place (State or Foreign intry)
,	aryland show		10a. State 10b. County	10	c. City, Town	or Location					10d. Inside City Limits
	ith the Ma or 28e-f s	Director	MD Baltimor	e City F	Baltimo	ore					1 Yes 2 □ No
	ath with t 23a or 2 ust be n		10e. Street and Number 3211 Guilford Aver	110		10f. Zip Code 21218			10g. 0	Citizen of What Cou	untry?
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	city Yes or N		14. Race - Amer	
036	ours after des rel', or items Examiner m	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:	Hican, etc.)		Black, White	
215-0	within 72 hours after death with the Maryland ene. than "neturel", or items 23s or 28e-f show its Mudical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	nation during most of working	ng		Kind of Business/II Home	
2	led wii lygien her th nt, I're		9		Hon	nemaker					
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryle if Health and Mental Hygiene. Item 27 ie marked other than "neturel", or frems 23a or 28e-f sho other treumetic event, Ins Mudical Examiner must be nutified at	To Be	17. Father's Name (First, Middle, Last) Emory Glenroy Kear				18. Mother's Name Winona Sy	lvia Kr	nick	man	
Mar	d 2 sh th and the m treum		19a. Informant's Name/Relationship (7 Donna Chaplinski /	урө, Print) Sister		Mailing Address (Street Maple Lane					p Code)
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tret <u>once</u> .		20a. Method of Disposition	2	20b. Place of	Disposition (Name of c, crematory or other place	D	ate		Location - City or T	own, State
Baltimore,	Page ment c ent: If ury or	ij	1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify			eake Cremat	· 1 F	'eb 5 005	Bel	tsville,	Maryland
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licen	M00	986	22. Name and Addre		Alter	nati	ves	
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P.O. Box 68760	The law requires that the death certificate be executed attenance bean signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _				23d. Date of deliv Month	ery Day Year
	w requires that been signed should be de	ρ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in	the underlying cause give	en in Part I.				he cause of death?
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f Vita	Phyeiclen: The raths certificate har all director, page	To Be	25. Was case referred to medical examiner? 1 XYes 2 \sum No	Hospitaf: 1 ☐ Inpatient	2 ☐ ER/Out	patient 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hom			6 Other (Special	at scene
0 0	tending Ph leath. Ior: After th the funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Found, Day Ye	28b. Ti	me of 28c. Injury World World	/ at 2 </td <td>8d. Describe I</td> <td>how inju</td> <td>ıry occurred</td> <td></td>	8d. Describe I	how inju	ıry occurred	
Division of	or At offer of Direct in by	Certification:	2 Accident investigation 3 X Suicide 6 Could not be 4 Homicide determined	1-29-05 28e. Place of Injury - building, etc. (S)	1:3 At home, farm pecify)		2	8f. Location (S City or Tox	Street a	ested dru nd Number or Rura 9)3211 Gui	ngs Land Ave.
	Hoepita 14 hours Funerel tely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my ner: On the basis of exa	v knowledge	death occurred at the tim for investigation, in my op	se date and place a	nd due to the	Cauco/e	Maryland s) and manner as s nd place, and due to	tated. o the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier			29c. License				ate signed (Month,	
			Theodore M.	Hi & my	(learn ac.)	OCM				nuary 30,	
			30. Name and address of person who c THE OF DIE M. K. 31. Date filed (Month Pay Year)	9-		111 Penn St	reet, Bal	timore	, Ma	aryland 2	1201
	Sta Registr		FEB 04-2	32. Agistrar's S	orgnature	Kneel					

	•			Please	Type or Prin					-		_	
			for State Registrar		State of Ma	aryland	•	artment of F <i>rtificate of</i>		and Mental	Hygiene Reg. No	1000	03300
	Physici	an	1. Decedent's Name (Fire	rst, Middle, Las	t)					2. Date of Month	Da		3. Time of Death
	/Medi	al	Anna J. Owe		(atmost and number)			4b. City, Town, o	r I continu	Febru		2005 County of Death	1:30 A M
	Examir	er	Stella Mar:					Towson	Location	or Dealtr	1	altimore	County
	Funeral		5. Social Security Number	er 6. S		e (In yrs. las	,,	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date o	f Birth n, Day, Year,		place (State or Foreign ntry)
	Director		218-05-467. Usual Residence of Dece	5		89	Yrs.			Aug 2	9, 19	l6 Mary	land
	yland now			. County		10c. City	Town or Lo	ocation					10d. Inside City Limits
	3a-f st	ctor	Maryland Ba	altimor	e	Peri	у На	11					1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 7613 Belair					10f. Zip Code 212	226			tizen of What Cou	ntry?
	leath i	erai	11. Marital Status	I Koau	12. Was Decedent 8	Ever in U.S.	13.			ain? (Specify Yes o	U.S	• A • 14. Race - Ameri	can Indian.
036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f show ther the Medical Evantrar must be routhed at	Completed by Funeral Director	1 Never Married 3	_	Armed Forces? 1 Yes 2 2 If Yes, Give Year or Dates:	ło		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	gin? (Specify Yes o , Puerto Rican, etc.)	Black, White, Specify: Whi	etc.
21215-0036	hin 72 ho an "natur Medical	pieted		Decedent's Ed nly highest gra			16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most d)	of working	16b. K	ind of Business/Ir	dustry
7	filed within I Hygiene. other than ent, the M		10th Grade		N/A		Hous	ewife				own hom	e
Maryland	t be fill hotal H ed oth	Be	17. Father's Name (First, Fred Janne)							r's Name <i>(First, Mic</i> zabeth Ja		Sumame)	
Ž	should nd Me mark imark	²	19a. Informant's Name/F	,	ype, Print)		19b. Mailir	ng Address (Street		r or Rural Route No		or Town, State, Zij	Code)
Ĭ,	and 2 alth a 27 is		Mrs. Kathy	White			88 L	iswell Dr	ive	Feeding H	Hills,	MA 010	30
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other til any injury or other traumatic event, III ODGE.		20a. Method of Disposition		Removal from State	cem	etery, crei	osition (Name of matory or other plac		Date	20c. L	ocation - City or To	own, State
	rtmen rtant: njury		4 □ Donation 5 □			Gard		of Faith				rlea, Ma	ryland
g	Depa Impo any i		21. Signature of Marie	Selvice Licen			M.	iller-Dip	pel F	uneral Ho d_Baltin	ome, I	nc. MD 2120	6
	Physician /Medical Examiner		23a Part1. Enter the dis shock, of heart failt Immediate Cause (Final disease or condition resulting in death)	ure. List only	ilications that caused one cause on each lin a. CORONAF Due to (or as a	e. RY ART	Do not ent	er the mode of dyin					Approximate Interval Between Onset and Death
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JINISI	or Attendater death Diractor: in by the	Certification:	2 Accident 3 Suicide 6 Homicide	investigation Could not be determined	28e. Place of Injubullding, etc	ry - At home . (Specify)	, farm, str		.03 20.1	28f. Locatio	on (Street an Town, State	d Number or Rura)	l Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 X (Check only one)	Certifying Phy Medical Exam	sician: To the best of iner: On the basis of and manner stat	examination	dge, death and/or inv	n occurred at the time vestigation, in my of	ne, date and pinion, death	place, and due to a occurred at the tir	the cause(s) ne, date and	and manner as si place, and due to	ated. the cause(s)
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	\cap		30. Name and address of	f person who c	ompleted cause of de	ath (Item 23	a) (Type,		. , . 2	- 3	1 (MAK	
	1		DR. TARIQ	MAHMOO	2300 DU	LANEY	VALL	EY RD.	TIMONI	UM, MD 2	1093_		

State Registrar



		1 - For State Unpend Registrar	d Item	State 23a,2	of Ma 27,28a	ryland i-f p e	/ Depa e r .me	artmen G840 rtificati	t of H 2-9 e of L	ealth Death	and N tas	Mental Hy	giene Reg. No.	200)5	0.330	1.1
Dhysisis		1. Decedent's Name (Firs	st, Middle, La	st)								2. Date of De Month	ath Day	, Y	'ear	3. Time of Deat	th
Physicia: /Medica		Joseph				ctell						Januar	_			06:22 P	• M
Examine	r	4a. Facility Name (If not in								Location				County of			
		Harford Mem 5. Social Security Number				(In urs las	st birthday)			e Gra		8 Date of Bir			d Cou	nty e <i>(State or For</i>	oian
Funeral Director		209-14-160		1 25 M 2□ F	_	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 1	1^{y} , Year)	26 F	Country	lphia,PA	A
		Usual Residence of Dece	dent													<u></u>	
riylan	_	10a. State 10b.	Cecil				Town or Lo								10d.	Inside City Lin 1 ☐ Yes 2 ☑	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: It item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 3 □ Widowed 4 □ □		Armed 1 XYe If Yes,	ecedent Ex Forces? es 2 No Give r Dates:			Was Deced f Yes, spec 1 ☐ Yes	offy Cuba	spanic Or n, Mexica Specify:	n, Puerto	ecify Yes or No Rican, etc.)	-		American White, etc. Whit		
5-0 72 hg 72 hg	Completed	15. E (Specify on	Decedent's E	ducation ade complete	ed)		(Give	dent's Usua kind of wo	rk done d	urina mos	t of work	ing	16b. Ki	nd of Busin	ness/Indus	try un	k
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Maryland 21215-0036 nd 2 should be filed within 72 hours att lith and Mental Hygiene. 27 Is marked other than "natural", or rireumatic event, the Medical Exam	10 Be	Jose	eph P	urtell													
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I Records, The law requires t cate has been signe page 2 should be completed by												24a. Was autop perfo 124 Yes	sy rmed?	prio dea	or to comple	findings availa etion of cause	ble
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Oivision of Vital or Attending Physician: Tafter death. Director: After this certification by the funeral director, posterior, posterior of the control of	LILICA	2 Accident 3 Suicide 6 4 Homicide	Could not b determined	e 28e. Pla	ace of Injury	y - At hom				A		28f. Location (S City or Tow			Regan	Road Road	
Division C To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funeral	Cal Ce				the best of						id place,	and due to the ded at the time,	cause(s)	and manne			
the I	Med	опе)		and m	anner state	ed.			License	_					Month, Day		
To With With Con.		29b. Signature and title o	etz	`					OCM	Œ			Janu	ary 2	27, 20	005	
		30. Name and address of ANA	person who					1 Per	ın St	reet	, Ba	1timore	, Ma	rylan	nd 212	201	
State Registrar 31. Date filed (Month, Day, Year) 2005 32. Registrar's Signature																	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:35 AM JANUARY Bernard 31 2005 Petrunich /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Potomac Manor Care Potomac Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 29, 1916 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Mount Olive, IL 1**X**M 2□ F 88 329-12-1073 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23e or 28a-f ehow Examiner must be notified at MD Montgomery Potomac 1 ZYes 2 □ No Direc 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 20854 10714 Potomac Tennis Lane USA Pages 1 and 2 should be filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 □ No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced "natural" the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Postmaster 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nt of Health and Mental H
t: If item 27 is marked ott
y or other traumatic even Be Catherine Mihalic Michael Petrunich ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Schoppman / Daughter 24 Calabash Court Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State Mount Olive, IL pernit. Page Department of Important: If any injury or once. Calvary Cemetery 2005 * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc 2 1501 Fast Fort Ave. Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner ise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last De to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of) Box 68760, physician Physician/Medical the t as attending p IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 SNo 24a Was an page 2 certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 %Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai or 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of contifue 29c. License number 29d. Date signed (Month, Day, Year) D3579 an to completed cause of death (Item 23a) (Type, Print) so, w. EDMONSTON DR, ROCKVILLE, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1 - State Amend Item 24a per	of Maryland / Depart Verb., G840, 02,40	ment of Health and I 4/05dhb icate of Death	Mental Hygien	e 2005 03303
	Physici /Medio		1. Decedent's Name (First, Middle, Last)		Pittman	2. Date of Death Month Da	ay Year 3. Time of Death 23, 2005 1742 PM
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give street and not be sold) 5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birthday)	O. City, Town, or Location of Death C. L. C. C. C. C. C. C. C. C. C. C. C. C. C.	8. Date of Birth	9. Birthplace (State or Foreign
	Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	IMORE		10d. Inside City Limits 1 1 Ves 2 □ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 3707 LYNDALE	1	0f. Zip Code 2/2/	_	itizen of What Country? U.S.A.
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show disal Examinat must be molfited at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, G Year or D	2 V No ive 1 🗆	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puert Yes 21 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give kind	s Usual Occupation of work done during most of work NOT use retired) OMESHC	king 16b. k	Cind of Business/Industry PRIVATE
Maryland	should be filed and Mental Hygie markad othar umatic evant,	To Be C	17. Father's Name (First, Middle, Last) CURHS BUCKNE	ER'	18. Mother's Nan	ne (First, Middle, Maider AHRICE	n Sumame)
_	is 1 and 2 sho of Health and Itam 27 Is ma othar traum		19a. Informant's Name/Relationship (Type, Print) ALBERT PHMAN, SR · / 1 20a. Method of Disposition	HVSBAND 3707 L	ddress (Street and Number or Ru-YNDME AVE.	BATIMON	
Baltimore	permit. Pages Department of I Important: If It any injury or o		1 Derial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser	State Cometery, cremator Mule LAND 22. Na 44	MEMORIM 2: me and Address of Facility VA		TI, MORC, MARYLAND SREENE FINERICHM RE, MARYLAND 21212
	Physician /Medical		23a. Part1. Enter the disease or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not enter the each line.	e mode of dying, such as cardiac		Approximate Interval Between Onset and Death
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876Ó,	ate be executed hysician and the burial-transit	Ical Examiner	that initiated events c.	(or as a consequence of):			
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	nant at time of death 5 Deth	opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to d			23e. Did tobacco	use contribute to the cause of death?
of Vital Records,		Completed	Chronic Obstructive	e Pulmonan	y Disease	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
Vita	Phyaician: this certificatal director.	o Be	25. Was case referred to medical examiner? ↑★ Yes 2 □ No Hospital: 1 □	Inpatient 2₺ ER/Outpatient 3	Othor	th (Check only one) ome 5 Residence	6 Cother (Specify)
n of		-	27. Manner of Death 28a. Date	of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how injur	
Division	tan Jeat tor: the	Certification		e of Injury - At home, farm, street, ing, etc. (Specify)	d 1 ☐ Yes 2 ☐ No factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospitel or At within 24 hours after or To the Funeral Directorpletely filled in by	edical ((Check only 2 Medical Examiner: On the b	e best of my knowledge, death occ pasis of examination and/or investi oner stated.	curred at the time, date and place, gation, in my opinion, death occur	and due to the cause(s rred at the time, date and) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	D	29c. License number DZ8637	0	te signed (Month, Day, Year)
			30. Name and address of person who completed cause Edurand 5. Bull man.	se of death (Item 23a) (Type, Print	view Nedi	ist Conti	212
	Sta Registr	te ar	30. Name and address of person who completed cause Edward 5. Bessman 31. Date filed (Month, Day, Year) FEB 0 4 2005	Register's Signature	parte		
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			For State Registrar	State of Maryland / Department / Ce	artment of Health and I rtificate of Death		ene 005	03304
	Physici		1. Decedent's Name (First, Middle, Last			2. Date of Death Month		3. Time of Death 5:50 A M
	/Medic Examir		4a. Facility Name (If not institution, give University of MD	street and number) Medical Center	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se 7. Security Number 6. Se 10 Usual Residence of Decedent	7. Age (In yrs. last birthday) M 2 F Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth 9. Birth 9. Sirth 100 100 100 100 100 100 100 100 100 10	nplace (State or Foreign untry)
	with the Maryland ta or 28a-f show the notified at	ctor	10a. State 10b. County	10c. City, Town or Lo Baldine				10d. Inside City Limits 1 ⊠des 2 □ No
	death with the	ral Director	10e. Street and Number 2/2/ Fairm		10f. Zip Code 2/223		g. Citizen of What Co	•
980	or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 12 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: 3/a	e, etc.
21215-0036	n 72 ho "natul	Completed	15. Decedent's Edu (Specify only highest grad	ucation 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business/	
	filed Hygi other	Be	17. Father's Name (First, Middle, Last)		18. Morner's Nam	ne (First, Middle, M	Home Indianal A	prodement
Maryland	nd 2 should be lth and Mental 27 is marked of r treumatic ev	2	19a. Informant's Name/Relationship	ype, Print) 19b. Maili ()(1,224 SD ~ 45/1	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, 2	
Baltimore,	0 = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify,	Removal from State 20b. Place of Disponsional from State	matory or other place)	Date 2005 7	Oc. Location - City or 3	Fown, State
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	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications the caused the death. Do not entine cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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rds, P.O.	w requires that to been signed by should be detact	d by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	as b	ompiete				24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
/ital	Physicien: The this certificate har al director, page	ВеС	25. Was case referred to medical examiner?			th (Check only one)		
on of \	fing Physicien: After this certific funeral director,	lon; To	27. Manner of Death 1 ANatural 5 Pending	Hospital: 1 Inpatient 2 □ ER/Outpatier 28a. Date of Injury (Month, Day Year) Injury		ome 5 ☐ Residen 28d. Describe how	ce 6 Other (Spec	ify)
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	e Hospite 24 hours e Funere letely fille	Medical C		rsician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.				
)	To th within To th comp	Me	29b. Signature and title of certifier	Zilish MO	29c. License number P 8578		d. Date signed (Month	
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type.	Print) e St Baltimar	e, MD a	21201	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	e St Baltimor			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** DANIEL F. ROSS Feb. 1, 8:30A M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3909 Prospect Road Street Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2 F Days Yrs 81 **Director** 223-26-3445 10/1/1923 Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at MD Harford Street 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 23a or 3909 Prospect Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 □ No If Yes, Give or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specity: λq Specify: White 3 Widowed 4 Divorced Year or Dates: WWII "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alex M. Ross Dema Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Ross/Wife 3909 Prospect Road, Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of i Importent: If it any injury or o 1

Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Mt. Nebo Cemetery 2/5/2005 Delta, PA 21. Signature of Edheral Service Licer 22. Name and Address of Facility Harkins F.H.Inc., Delta, PA 17314 povellase 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced in the cause) Due to (or as a consequence Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the use as attending p 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by ACCIDEN BROVASCULAR 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one 1 Yes 2 No Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
Injury at 28d. escribe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Peat 28c. Injury at Work? Certification: 28b. Time of 1 Natural
2 Accident 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C o the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) Feb. 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl Spector, 2014 Tollgate Rd., Suite 200, Bel Air, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2005 > Moseras Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Robert M. Rawes January 28, 2005 3:16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 225-16-2888 85 1-19-1920 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Gambrills the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2490 Bell Branch Rd. 21054 USA death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces: 1 XYes 2 □ No If Yes, Give Year or Dates: W.W. II Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 XWidowed 4 ☐ Divorced "natural", or then "natur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the M Federal Government 12th Manager. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Rawes Gertrude Pauliss 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda L. Stonebraker/ Daughter 2107 Bennett Point Rd., Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Depertment of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 1-31-05 Edgewater, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 Ufle word o Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition **Physician** neumonio resulting in death) /Medical Due to for as a consequence of) Examiner auro Sequentially list conditions, if any, leading to immediate cause Entar Underlying Cause (Disease or injury Due to (or as a sinsequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien a Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown þ signed b Part II. 9ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 🗌 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page this certificete 1 Yes 2 No 1 Yes 2 No director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Chath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Dir the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 ame and advess of person who completed cause of death (Item 23a) Type, Prixt) Va rot To 16 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04 2005 Registrar

			1 - For State Registrar	State of I	/larylar		artmen					giene Reg. No.2	005	033	07
	Physici	an	Decedent's Name (First, Middle,								2. Date of Dea	Day	Year	3. Time of E	Death
	/Media		Samue1		ffe1						Januar		2005	8:30	a ^M
7	Examir	er	4a. Facility Name (If not institution, g 804 Bermuda Co		or)		,		Location (of Death			unty of Death	1 . 1	
	-				Age (In vrs.	last birthday)	If Under	napo 1 Year	IIS If Under	24 Hrs.	8. Date of Birt	th	nne Ar		Foreign
	Funeral Director		405-18-8332	1 X XM 2□F	82	Yrs.	Months	Days	Hours	Min.	June 2	y, Year) 2,1922	Ken Ken	place (State or ntry) tucky	
	ס		Usual Residence of Decedent												
	arylar show	<u>.</u>	10a. State 10b. County		10c. Cit	ty, Town or Lo	ecation							10d. Inside City 1 ☐ Yes	
	8a-f	ecto	MD Anne A	runde1		Annapo		0.4.				40 02	-/.110		-X
	with t	Dir	10e. Street and Number				10f. Zip		0.1			-	of What Coul USA	ntry ?	
	eath	erai	804 Bermuda Co	12. Was Decede	nt Ever in U	.S. 13.1	Was Deced	214 ent of Hi		gin? (Sp	ecify Yes or No		Race - Americ	can Indian,	-
"	72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteul Exarrar at must be trolliket al	by Funeral Director	1 ☐ Never Married 2 X Married	Armed Force	s? TNo					, Puerto	ecify Yes or No- Rican, etc.)		Black, White,		
21215-0036	ral', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	: 1942	-46	1 ☐ Yes 2	XXNo	Specify:			Spi	ec <i>ify:</i> W	hite	
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>uring</i> mos	t of work	ing	16b. Kind o	of Business/In	dustry	
21	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4d	r 5+)			e retired,) -			D 1			
	iled v Hygiei ther ti		17. Father's Name (First, Middle, La	4		Exec	utive		18 Mothe	ar's Name	(First, Middle,	Packa Maiden Sur			
and	d be f ental h red of	o Be	Elias Raffel	,						a Lot			,		
Maryland	should nd Me mark matic	ပ္	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a			al Route Numbe	er, City or To	wn, State, Zip	Code)	
	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ther traumatic svent, it. Me		Harriet Raffel	(Wife)		804	Bermu	da C	ourt,	Anı	napolis	, MD 2	1401		
Je,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28a-1 show or other traumatic svent, the Medical Examinating be rediffed at		20a. Method of Disposition			Place of Dispo	sition (Nam	e of her place	a)	[Date	20c. Locati	on - City or To	own, State	
E	Page nent c ant: If		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	02/02	2/2005	Crown	sville	, MD							
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Service Li	ensee		22	Name and	Addres	s ol Facilit Fune	ra1	Home P.	Α.			
_	g 0 = 9 0		17000		-		12 R	idge	ly Av	enue	• Annar	olis,	MD 21		
			23a. Part1. Enter the disease, or a shock, or heart failure. List or	Implications that caus ily one cause on each	ed the deat	h. Do not ent	er the mode							Approximate Interval Betwo Onset and De	een eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	010	15/2	110	-	a	no	conc	mo	ma	_	
	Examiner			Due to (or a	as a conseq	uence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a conseq	uence of):									
	outed od ransit	Examiner	that initiated events	c											
0	e exerian ar	EX	resulting in death) Last	Due to (or a	as a conseq	uence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical		d		-									
9	that the death certific ed by the attending p detached for use as	Med	IF FEMALE:	23c. If yes, outcon	o of progna	nov						1			
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Feta	Ideath 3	Ectopic pre					23d.	Month	ery Day Ye	ar
o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown		eath 3L	1 Other (Spe	-cuy)							
<u>α</u>	that hed by deta	by Ph	Part II. Other significant conditions	s contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use o	ontribute to th	ne cause of de	ath?
Records,	w requires that s been signed t should be deta	ed be									1 🗆 Y	es 2□N	o 3 ☐ Prob	ably 4 In	known
000	aw re	Completed									24a. Was autop	an 24	b. Were auto	psy findings av	/ailable
Ä	The ate h page	mo:				10	NR.		_		perfor	med?	death?		130 01
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			100				of Death	(Check only o	ne)			
of \	shysi this c	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien			4 🗆 140	rsing Ho			Other (Specif	y)	
n C	ding F	lon	27. Manyer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	Day Year)	28b. Time of Injury	M	Bc. Injury Work	at ? ′es 2 ⊟i		28d. Describe h	low injury oc	currea		
Division	I or Attending after death. Director: After I in by the fune	ficat	2 Accident investigat 3 Suicide 6 Could not	be ORe Place of	niurv - At ho	ome, farm, stre					28f. Location (S	Street and Nu	ımber or Rura	l Route Numbe	er,
Βį	ater after Direct d in by	Certification:	4 Homicide	building,	etc. (Specify	y)	,				City or Tow	m, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			Physician: To the be											
S	he He in 24 he Fu pletel	edical	(Check only 2 Medical Ex	aminer: On the basis and manner	of examina stated.	tion and/or ins	estigation,	in my op	inion, dea	th occurr	ed at the time, o	date and plac	ce, and due to	the cause(s)	
\	Vith To t	Σ	29b. Signature and title of certifier				29c.	License	number	(12		29d. Date sig	ned (Month,	Day, Year)	
)		·	1	110	' (7/		1/	1/05		
16			30. Name and address of person w	,					۸	1 4	- 300	1/01	,		
1	Sta	to	Goldstein 1 31. Date filed (Month, Day, Year)	16 Defense	High strar's Signa	way, 4	cn Flo	oor,	Anna	iboT1	s, MD 2	1401			
	Sta Registr			2005	the St	1	ME								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** Schlining January 27 06:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

May 1, 1909 Wicomico Atria of Salisbury 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral XXM 2□F 95 Director Maryland <u>081-03-5363</u> Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23e or 28a-f show freumatic event, Ite Mudical Examiner must be notified at 1 ☐ Yes XXNo Directo Maryland Wicomico Pocomoke City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21851 102 Front Street Funera 12. Was Decedent Ever in U.S. Agned Forces? 14⊒ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed withIn 7 I Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) IRS Agent government 12 should be filed w h end Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna B. Lindenberger Walter Schlining 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health enc Importent: If Item 27 is n any injury or other treun Barbara Witt - daughter 29 Salt Grass Raod, Ocean Pines, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 1/29/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatury o Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List dny one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALMENOSCIENOME CARDIOUNSCULAR DISEASE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) _ P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Failure TARIUE 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s certificate has autopsy performed 1 ☐ Yes 20 No Division of Vital Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Cother (Specify) ASS ISI SATI 1 Yes 2 10 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 732014 Many wounder 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 milpord St 504 B SalisBary MD 2804 MALLISH MOSUNEA 32 pegistrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2005 H Greeke Registrar

			1 - State of Ma	ryland / Depa <i>Cei</i>	artment of Hertificate of D			giene Reg. N2 0 0	5 03309
	Physici		1. Decedent's Name (First, Middle, Last) James Denlock Smith, J	r.			2. Date of De Month	Day	Year 7.23 PM
	/Medie Examir		4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy Ho	spital	4b. City, Town, or I Baltimo		h	4c. County o	- 0
	. Funeral Director		219-34-2066 1X3M 2□F	(In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da NOV • 2	18, 1938	9. Birthplace (State or Foreign Maryland
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/S	10c. City, Town or Lo Balt	cation cimore				10d. Inside City Limits XXYes 2 □ No
	with the 3s or 28s	Funeral Director	10e. Street and Number 4320 Clareway Apt. 7T		10f. Zip Code 21213			10g. Citizen of W USA	nat Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show may injury or other traumatic event, it a Modical Examination must be notified at ance.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★ Divorced 12. Was Decedent Et Armed Forces? 1 □ Yes 2 □ Note If Yes, Give Year or Dates:	0	Mas Decedent of His f Yes, specify Cuban l □ Yes 2⊠ No		Specify Yes or No to Rican, etc.)		- American Indian, , White, etc. Black
21215-0036	d within 72 ho giene. er than "natur r tre Medical"	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+ 10th grade	(Give	dent's Usual Occupat kind of work done do DO NOT use retired)	tion uning most of wo	rking	16b. Kind of Bus	ortation Co.
land	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, It a Max	To Be C	17. Father's Name (First, Middle, Last) James D. Smith, Sr.			Carrie	Thomas		
altimore, Maryland	s 1 and 2 sho f Health and I item 27 is me other traume		19a. Informant's Name/Relationship (Type, Print) Alicia Ali-Hamilton/Daug 20a. Method of Disposition	8601	Glen O	aks Bl		Valley 20c. Location - C	tate, Zip Code) 91352 California City or Town, State
Baltimo	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra <u>once</u> .		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	natory or other place int Ceme Name and Address 240 Reis	cery	atman-N	Tarris I	ore, Maryland Cuneral Home ce,Md 21215
8760,	Physician /Medical Examiner and the printing	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	э.	n Static	Curc		llest,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
of Vital Records, P.	w requires that the been signed by should be detact	ρ	Part II. Other significant conditions contributing to death but	1 1	nderlying cause giver	n in Part I.	23e. Did to	Yes 2 No	oute to the cause of death? Probably 4 □Unknown ere autopsy findings available
al Re		Completed	OS Wassessian de madical				autop perfo 1 Yes	osy promed? de	or to completion of cause of ath? Yes 2 No
Division of Vit	ding Phys h. After this funeral di	Certification; To Be	25. Was case referred to medical examiner? 1		t 3 DOA Other	4 Nursing h	28d. Describe t	dence 6/10ther	1
Divi	or A	Certifle	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tov		or Rural Route Number,
	To the Hospital within 24 hours and To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or inv	estigation, in my opi	nion, death occu	urred at the time,	date and place, ar	d due to the cause(s)
)	To the within To the comple	2	29b. Signature and title of certifier M0		29c. License			A	(Month, Day, Year)
5	1		30. Name and address of person who completed cause of dea	I Paul 6	0 11'	MONE	md.	21202	
9	Sta Registi		31. Date filed (Month, Day, Year) 32. Registu FEB 0 4 2005	's Signature	Sparte				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan 2005 Year **Physician** James F. Spicer 10:25 AMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Nursing Home Ha11 Charlotte Hall St.Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex XX M 2DF **Funeral** Director 577 24 5083 82 Jan 9,1923 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-f show Examiner must be reatified at 1 ☐ Yes 2√ No Director Maryland Calvert Owings, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1890 Skipshawn Lane 20736 United States or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ YYES 2 □ No WW 1 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No 3 Widowed 4 Divorced White "netural', event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Ret. Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin F. Spicer Mary Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita R. Spicer (Wife) 1890 Skipshawn Lane, Owings, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 2, 12005 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny injury or once. Resurrection Cemetery Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophye **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed gorno attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by sign d be 1 Yes 2 No 3 Probably 4 dinknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 2 NO To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 0119 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 04

			For State Registrar	State of Maryla		artment of <i>rtificate o</i>			iene _{eg. No} 20 (05 03311
	Dharia		Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medi		Raymond M. Sade					JANUAF	(Y E8, c	WWW leles Min
	Examir	ner	4a. Facility Name (If not institution, give s Saint Joseph I		nter	4b. City, Towr	n, or Location of D	Peath √SON	4c. County of	of Death Saitimore
	Funeral Director		215 34 9664 x	M 2□ F 68	rs. last birthday) Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of Birth Win. (Month, Day December	, Year)	9. Birthplace (State or Foreign Country) Baltimore, Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Li	ocation				10d. Inside City Limits
	Ba-f sho	Funeral Director	Maryland Baltimore	Bal	Ltimore G					1 Yes 2 No
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	ns 23	era	1628 Gray Haven Court	12. Was Decedent Ever in	U.S. 13.	21222 Was Decedent of	of Hispanic Origin	? (Specify Yes or No-	USA 14. Race	- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, the Medical Examinar must be notified at once.	by Fun	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify C 1 ☐ Yes 2 1 1		uèrto Rican, etc.)	Specify:	white, etc.
8	2 hour	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Bus	
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Maryland	d be fill antal H sed off	Be	17. Father's Name (First, Middle, Last) Michael Syrja Sade				_	Name <i>(First, Middle, I</i> a Toth	<i>Maiden Suma</i> me	9)
Σ	2 should and Me is mark	2	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Address (Stre		r Rural Route Number	, City or Town, S	State, Zip Code)
	aith a aith a 27 is		Christopher R Sade		2402	Sandwich	n Gourt	Crofton, Mar	vland 211	14
altimore,	Pages 1 and of He ant: If Item		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	osition (Name of matory or other p	olace)	Date	20c. Location - (City or Town, State
ij	artme ortan injury		 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License 		2:	2. Name and Ad	February 1 dress of Facility		Baltimore,	Maryland
ñ	Depariment Department of the once.		Mathou Hospino	Changelli]	assahn Fl WO1 Belai	ineral Home	e Inc Ltimore, Mary	ond 2123	X
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	cuted nd ransit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events							
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rds	w requires been sign should be	ed b	CONGESTIVE HEART	FAILURE				1 <u>Y</u>	s 2 No	3 ☐ Probably 4 ☐Unknown
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1	1		30. Name and address of person who co	mpleted cause of death (I	- € tem 23a) (Type,		Been T May bed T		1	1
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	Examir	er	4a. Facility Name (If not institution, g	give street and number	er)		4b. City, Town, or		f Death		4c. County of	Death
	*			Avenue 7.	Age (In yrs. las	t hirthday)	Baltimo	re If Under 2	24 Hrs.	8. Date of Birth	N/A	Birthplace (State or Foreign
	Funeral Director		218-14-7417	1□M 2KIF	93	Yrs.	Months Days	Hours	Min.	Month, Day,	Year)	Country)
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	how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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	ter de Item	Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Force	s?	15.	f Yes, specify Cuba	n, Mexican	, Puerto R	lican, etc.)		White, etc.
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ē,	- 2 5 5		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Plac		sition (Name of matory or other place		Da	-	20c. Location - Ci	ty or Town, State
9	Page lent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from Sta cify)	10		Cemetery	1	2/05	/2005	Raltim	ore MD
Baltimore,	perrit. Pages Deportment of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lic	censee	_		. Name and Addres	s of Facility	/			
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	pitel		29a. Certifier 12 Certifying	Physician: To the be	est of my knowle	edge deat	n occurred at the tim	ne date and	dintage ar	nd due to the ca	use(s) and mann	er as stated.
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	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier		Λ		29c. License	number				Month, Day, Year)
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1.	14		30. Name and address of person with	1			Print)					1
1	13		Dr. Carla Ros	enthal 34	14 St.	Pau1	St. Ba	1timo	re l	MD 212	18	
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DI.	hysici	an	1. Decedent's Name (First, Middle, Last)	T) C				2. Date of Death Month	Day Year	3. Time of Death
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Fui	neral		Social Security Number	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days			year) 9. Bir	thplace (State or Foreign ountry)
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To the within To the	com	M	29b. Signature and title of certifier	MN	1	29c. License		290	Date signed (Montl	
	lá		30. Name and address of person who con		23a) (Type, I		175		1/28/05)
4	(0)		Michael Yno	22. S. Gre	ene	st. B.	Himor	MD	1201	
R	Sta: egistra	_	31. Date filed (Month, Day, Year) FEB 0 4 200	32. Segistrar's Signatu	4 de	arti				

amend item#4a, 10e, 19b, perMD, FH, C841-3/3/05 TT The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year /Medical Dorothy Tolson 30 2005 11:25 4a. Eggility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2426 N. Ellamont Street Balto If Under 1 Year
Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 1 XI F Hours Min Director 220-30-4715 Yrs. 10-7-1913 Md Usual Residence of Decedent death with the Maryland worde 10a. State 10b Counts 10c. City, Town or Location other traumatic event, the Madical Examinar is ust be nutified at 10d. Inside City Limits Md N/A Director Balto 28a-f 1 XYes 2 No 10e 2428 and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2426 N. Ellamont Street Funeral 21216 U S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Black natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "any injury or other traumatic event, ITE Magnetic applications. Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic 7th grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Tolson Mary Gibson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Jones - Sister Balto, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2-3-2005 Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ofiset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Story rever decese Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐ Pregnant at time of death Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 should Completed 1 🗀 Yes 2 🗆 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has autopsy perform certificate 2 No Vital 1□ Yes 1 ☐ Yes 2 ☐ No Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 🗌 Yes 2 No ŏ filled in by the funeral 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: : After 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examiner stated. ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MI 30. Name and address of pe's cause of death (It 1838 Greene Tree 21208 31. Date filed (Month, Day, Year) State Magistrar's Signature Registrar 04 2005

			State of Maryland / Department of Health and Mental Hygiene 1- For Registrar Certificate of Death Reg. No. 2 0 0 5 0 3 3 1 5
	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, Last) Marvin Carlos Thornburg 2. Date of Death Month Day Year JAN 30 2005 8:13 PM 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 8:13 PM
	Funeral Director		CIVISTA MEDICAL CENTER 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex Paris T. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. S. Date of Birth (Month, Day, Year) June 29, 1916 Ohio
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Charles LaPlata 1 \(\text{Yes} \) 2 \(\text{No} \)
	leath with ti ns 23a or 2 nust Le n	eral Dir	10e. Street and Number 1368 Redwood Circle 10f. Zip Code 20646 10g. Citizen of What Country? U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
215-0036	hours after d ural', or Itan Il Examiner	d by Funeral	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Specify: White
-61212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hydiene. Important: If tian 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic evant. If a Madical Examinar must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Elementary (Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Machinist 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist Safeway Co.
Maryland	d Mental Hy narked oth natic evan	To Be	17. Father's Name (First, Middle, Last) Clarence Thornburg 18. Mother's Name (First, Middle, Maiden Sumame) Beda Arnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
re, Mai	tand 2 st Health and tam 27 Is n		Irma G. Thornburg (Vife) 1368 Redwood Circle LaPlata, Maryland 20646 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baitimore,	permit. Pages Department of Important: If i any injury or once.		Cedar Hill Cemetery Feb. 3,2005 Suitland, Maryland
	Physician /Medical Examiner	e.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
BOX 68/6U,	certificate be executed nding physician and use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
	w requires that the death certific: been signed by the attending pl should be detached for use as t	Physician/Me	in the past 12 months? 1
ecords,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
Ē	The larate has	Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical 26. Place of Death (Check only one)
ō	ding Physician;). After this certific funeral director,	2	examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
5	or Attanater death	Certification;	2 Accident investigation 3 Suicide 4 Homicide Accident investigation M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	o the Hospital ithin 24 hours (o tha Funeral ompletely filled	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To To CON	M	29b. Signature and title of certifier Pack 700 MD 29c. License number D-52289 29d. Date signed (Month, Day, Year) 1/31/05
1	5 7 Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALAN MATHUR MD 10 ST. PATRICKS DR. SUITF 404 WALDORF, MD 20603 31. Date filled (Month Day, Year), F.B. U.4 2005 32. Weistran's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 28 January Ellis Vermette 2005 1004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth
(Month, Day, Year)
April 26,1929 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months **™** 2□ F Yrs. Director Vermont 008-18-6851 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 📆 No Director Anne Arundel Shady Side 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1246 Hawthorne Street 20764 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: White Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 1946-52 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Vending 11 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H tant: If item 27 Is marked ot Evangelist Vermette Ethel Ludd ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2130 Horace Ward Road, Owings, MD 20736 Tim Vermette (Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 5 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 2/07/2005 Metro Crematory Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final 00000A **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence ol): ن Division of Vital Records, P.O. Box 68760, physician Physiclan/Medlcal the use as attending IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year jo Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ナナナシ 50 1 Yes 2 No 3 Probably 4 Proknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: or Attending I After Injury 5 Pending after death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Monty), Day, Year) 29b. Signature and title of certifier DOOY6303 \mathcal{O} 0106811A MORCO 190 d cause of death (Item 23a) (Type, Print) ess of person who 30. Name and add 310 32. Registrar stignature Registrar

			Please Type of Frint in black indelible ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene
			Registrar Certificate of Death Reg. No. 2000
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month Day Year 4c. County of Death 4c. County of Death
			1401 Edmondson Ave. Rultimore N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1
	Maryland f show	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 112 Yes 2 □ No
	with the I a or 28e-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Reference of Hispanic Origin?) 14. Race - American Indian, Black, White, etc.
21215-0036	hours after death with the Maryland turel', or Items 23a or 28e-f show all Examinations to actified at	þ	Armed Forces? 1 Never Married 2 Mar
15-(72 10 11 12 13	olete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working ifig. DO NOT use retired) 16b. Kind of Business/Industry
	filed within I Hygiene. other than *	Completed	Elementally/secondary (0-12) College (1-40r5+) Porter Giant Foods
Maryland	o d la o	To Be	John Henry Williams St. Mane (First, Middle, Maiden Sumame) Mary Coates
Man	BE a a		19a. Informant's Name/Relationship ype, Print) ughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	ges 1 and 3 it of Health if item 27 or other tra		20a. Method of Disposition (Name of cametery, crematory or other place) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State
Baltimore,	Pa Ther ury		"4 Donation 5 Other (Specify) Trinity Cemetery 47/2005 Dundak Nd.
Bal	permit. Departi Importi any inj		21. Signatore of Funeral Service Licensee 2. Name and Address a Facility Joseph L. Russ Funeral Home 2222 W. Not-th Ave. Boy to Md. 21216
	Physician		23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death
	/Medical Examiner		disease or condition resulting in death) Du⊲ to (or as a consequence ≠):
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
8760	# × 6	cai	d
Box 68	death certificat e attending phy d for use as the	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
P.O. B	0 0 0	Physician/M	in the past 12 months? 1
	The law requires that the the bas been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law resate has be page 2 sho	ompieted	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
/ital	icien: Th certificate ector, pag	Be C	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one
of	Phys this	-1	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
sion	Attending r death. sctor: After by the funer	catlor	1
DİVİ	Hospitel or At 24 hours after of Funerel Direct tely filled in by	Certification;	4 Homicide determined determined building, etc. (Specify) 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 287. City or Town, State)
	To the Hospitel or Attent within 24 hours after deall To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
1	To the within 2.	M	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
, I	d		30. Name and address of p rson who ampleted cause of death (Item 23a) (Type, Print) Ough M. Nogheira, MD 22 5 Greene 5t. Rn N3W143 31. Date fled (Mapth, Day, Year) Registrar's Signature
4			Joseph M. Nogheira, MD 22 3. Greene st. Ranks 143
	Sta Registr	te ar	31. Date filed (Marith Day Year) Registrar's Signature & Salt more of 2120

State of Maryland / Department of Health and Mental Hygiene $\supseteq 0 \cap 5$ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month 12:40pm м **Physician** Russell Raymond Wanke February 1,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 22, 1925 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 ☐ F 79 Yrs 206-16-0678 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b, County or 28a-f show in than "natural", or iteme 23a or 28a-f ehor Montgomery Silver Spring 1 XYes 2 □ No MD Completed by Funeral Director 10f. Zin Code 10g. Citizen of What Country? 10e, Street and Number 13908 Pond View Road 20905 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. importent: if item 27 is marked other than "ns any injury or other treumatic event, if a Madis once. Manufacturing College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick R. Wanke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13908 Pond View Road Silver Spring, MD 20905 Doug Wanke / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave. Baltimore MD 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnuemonia **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Congestive Heart Failure that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Tyes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 2 No 3 DOA Certification: To 1 Tyes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 🗌 Yes 2 No investigation 2 Accident the within 24 hours after deat To the Funerel Director: Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitei Medicai 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe To D61595

State Registrar

So

31. Date filed (Month, Day, Year) FEB 0 4 2005

Marjorie A. Pennant

19

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd. Silver Spring MD 20910 32. Registrar's Signature



			riease					of Hoolth and	-		•		
			1 = For State Registrar	State of Ivia	arytari	-		of Health and of Death			-2111	5 033	1 (
			Negistrar Negistrar Negistrar Negistrar Negistrar Negistrar Negistrar Negistrar	")			incate	Ol Deall!	2. Date of Deal	eg. No	0 0	3. Time of Death	1 ,
	Physici		Adrain Jame	o udlhal	_ т.				Month	Da		5.00.0	М
	/Medic Examin		4a. Facility Neme (If not institution, give		لبوالا		4b. City, To	wn, or Location of Dea	January		2005 County of De	9:55p	
			Doctors Community	Hospital				Lanham			Princ	e George's	
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs.	last birthday)	If Under 1 \ Months D			Year)	9. Bi	rthplece (State or Fore country)	ign
	Director		Usual Residence of Decedent		66	Yrs.			Nov. 7,	19		Virginia	
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limi	its
	Man	ţo	Maryland Prince	George 's			R	owie				M☐Yes 2☐N	NO
	or 28.	Director	10e. Street and Number	ocorge a			10f. Zip Co		1	0g. Cit	izen of What C	country?	
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itema 23a or 28e-f ahow ant, the Medical Examinat must be neithed at		15805 Pacific Cou	ırt				20716		Un	ited St	tates	
	er de	by Funeral	11. Marital Status	12. Was Decedent I Armed Forces?			Vas Decedeni f Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - Am Black, Wh		
36	rs afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Y Yes 2 □ N If Yes, Give Year or Dates:	lo	1	□Yes 2¶	No Specify:			Specify:		
9	2 hou	ed t	15. Decedent's Edu	ıcation		16a. Deced	ient's Usual C	Occupation		16b Ki	nd of Business	White	
215	hin 72 in na	Completed	(Specify only highest grad	le completed) College (1-4or 5	4)	(Give life. L	kind of work o	fone during most of wo etired)	rking	100.10	na or basines.	undustry	
2	giene giene er th	EO.	12th	College (1-40/3	*/		Sold	ier			Milit	ary	
pg	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle, A	Aaiden	Sumame)		
yla	Meni Meni Meni Meni Meni Meni Meni Meni	ပ္	Adrain James	Wilhelm				Hatti			Gordo		
Maryland 21215-0036	ages 1 and 2 should be filed within 72 hours atter death with the Marylan it of Health and Menth Hygiens. If the literant and Menther Hygiens "ratural", or litera 23a or 28e-1 ahow or other traumatic avant, it a Medical Examinat must be notified at		19a. Informant's Name/Relationship (T) Shirley M. Harris	γρθ, Print)				ic Court					
e,	1 and Healt am 2		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name o	of	Bowie, Ma		cation - City or		
Baltimore,	permit. Peges 1 and Department of Heall Important: If Itam 2 any injury or other 900ce.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	a	emetery, crem	natory or other	r place)			-		
Ħ	artme ortan injur	H	21. Signature of Funeral Service Lieegs		MD	Vetera:	Name and A	ddress of Facility	and the same of th			.e, Marylan	ıd
ä	Depa Impo any i		Muarita Rah	omar	M00	ora De	onalds	on Funeral napolis Roa	Home & C	rem	atory,	P.A.	
			23a. Part1 Enter the disease, or compleshock, or heart failure. List only o		the death						Haryre	Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	Seps								Onset and Death	
38	/Medical Examiner		resulting in death)	Due to (or as a		uence of):						Days	
Н	Examiner		Sequentially list conditions,	. Obst	ruct	ive Ja	undice					Days	
	ed sit	Examiner	Sequentially list conditions, if any, leading to transdict cause. Enter Underlying Cause (Disease or injury	Duly to (or as a	l Consayo	ienes of):							
	al-trar	xan	that initiated events resulting in death) Last	Due to (or as a	consequ	uence of):							_
760,	ate be executed nysician and ha burial-transit	calE		•									
	eath certificate attending phy for use as the												
Вох	th cer lendir r use	an/N	230. Was decedent pregnant	3c. If yes, outcome of	of pregna		Ectopic pregn	ancy		2	3d. Date of de	livery	
0.	by the att	Sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at			Other (specif				Month	Day Year	
<u>a</u>	The law requires that the death certifica te has been signed by the attending ph lage 2 should be detached for use as th	by Physician/Med	9 ☐ Unknown Part II. Other significant conditions con	stributing to dooth bu	t mat		dank dan as		on- Bida-b				
Records,	w requires that been signed t should be deta	d b	Hypertension	tinboting to death bu	1110(1650	wang in the bil	denying causi	e given in Fart i.			Se contribute to	o the cause of death? robably 4 \text{Unknow}	vn
200	w requ	ete											
Ke	The law ate has page 2:	Completed							24a. Was an autopsy perform	/	prior to death?	utopsy findings availab completion of cause of	10
_	CG 17	e Co	25. Was case referred to medical					CC Plans of Par	1 Yes 2-	○ No	1 ☐ Yes	2 X No	
<u> </u>	ysici us cer direci	0	examiner?	lospital: 1X Inpatier	nt 2 🗆 1	ER/Outpatient	3□ DOA	0	ath <i>(Check only one</i> Iome 5 🗆 Resider		□Other (Sne	city)	
D O	ding Ph h. After th funeral	T:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		28b. Time of	28c.	Injury at Work?	28d. Describe how			J., J.	
<u>0</u>	ottendir death. ctor: Al	atic	2 ☐ Accident investigation	, , , , , ,		,		1 ☐ Yes 2 ☐ No					
Division	of Attanding Physician: after death. Diractor: After this certific d in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At ho (Specify	me, farm, stre	et, factory, off	fice	28f. Location (Str. City or Town,	eet and State)	Number or R	ural Route Number,	
_	Hospitel 24 hours a Funerel C itely filled i		29a. Certifier 14 Certifying Phys	inian: To the heat -	(III)	ulodeo dest							
	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical	(Check only one)	ner: On the basis of and manner stat	exammat	ion and/or inve	occurred at the estigation, in r	ne time, date and place my opinion, death occu	red at the time, da	use(s) te and	and manner as place, and due	s stated. to the cause(s)	
	within 2 To the complet	Me	29b. Signature and title of certifier	7			29c. Lic	cense number	29	d. Date	signed (Mont	h, Day, Year)	
) Surser	MD				D 53411		J	anuary	30, 2005	
,	1/2		30. Name and address of person who co										
1	10		J. Shesadri	20 0			le Roa	d #103 Bot	wie, Mary	Lan	d 20716)	
	Stat Registra		31. Date filed (Month-EaBYelf) 4 2	005 32. Redistra	r's Signat	DI A	barte						

/Medi	ian	1. Decedent's Name (First, Middle, La	ist)	T7.					Date of Death Month	Day	Year	3. Time of Death
	cal	Djimitri	a stand and anabar)	Wigger					anuary	27 20	005	3:25 a
Exami	ner	4a. Facility Name (If not institution, given Chesapeake Hospi				thic	Location of	Death		4c. County		
Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last bi		r 1 Year	If Under 24	4 Hrs. 8.	Date of Birth (Month, Day,	Anne		place (State or Fore
Director		394-30-2382 Usual Residence of Decedent	X XM 2□ F	70	Yrs.	Days	Hours	Fe	eb. 24,	1934	Wisc	consin
how		10a. State 10b. County		10c. City, Tow	vn or Location							10d. Inside City Lim
8a-f s	Director	MD Anne Ar	undel	Annap	olis							1 ☐ Yes 2 😿 I
a or 2 ben		10e. Street and Number			10f. Z	p Code			10	g. Citizen of \	What Cou	ntry?
ms 23	Funeral	720 Darlow Drive	12. Was Decedent B	Ever in U.S.	13. Was Dece	2140		n? (Specify	Yes or No-	US 14 Bac		can Indian,
7 is marked other then "naturel", or items 23a or 28a-f show traumetic avant, Inv Modical Examinar must be notified at	/ Fur	1 Never Married XX Married	Armed Forces?		13. Was Dece If Yes, spi			Puerto Rica	in, etc.)	Blad	ck, White,	etc.
turel',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				Specify:			Specify	/: Wh	ite
n "nat	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)		i. Decedent's Usi (Give kind of w life. DO NOT i	ial Occupai ork done du ise retired)	tion uning most o	of working	16	6b. Kind of Bu	usiness/Ir	dustry
ar the	mo	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+) E1	ectrical				S	tate D	ent.	
d other	Be	17. Father's Name (First, Middle, Last))					s Name (Fir	rst, Middle, Ma			
and Melial hygielle. Is marked other then aumetic avant, the Me	2	Adolf Wiggert				į		Pfei				
27 Is r traun	0	19a. Informant's Name/Relationship (BARBARA WIGGERT	WIFE	72	o. Mailing Addres 20 DARLO	s <i>(Street au</i> W DRI	VE AN	or Rural Ro NAPOL	ute Number, (IS, MD 2	City or Town, 21401	State, Zip	Code)
f itam 27 I		20a. Method of Disposition		20b. Place o	of Disposition (Na	me of	1	Date	20	c. Location -	City or To	own, State
		1 ☐ Burial 2 XCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			Cremato		Jaı	n.28,2	2005 _B	altimo	re.	MD
Important: If any injury or once.		21. Signature of Funeral Service Licen	1599		22. Name a	nd Address	of Facility	1 Hom	e, P.A	a r c rmo	10,	ш
] <u>= 60</u>		23a. Part1. Enter the disease, or companies, or heart failure. List only	111		12 K1	.age13	<u>Aven</u>	ue, A	nnapol	is. MD	214	01
physician and street transit sthe burial-transit	i Examiner	resulting in death) Saus 101/ Est and to start of the st	Due to (or as a	sided (a consequence Disco	ongesti	ve He	art F	ai lur	e			6 years
bur	0											
by the attending ached for use as	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death time of death	5 ☐ Other (sp	pecify)	in Donal		Ogo Didasha	23d. Date Mor	nth	Day Year
oy the attending ached for use a	by	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	1□Live birth 2 4□Pregnant at t 9□Unknown	2 Fetal death time of death	5 ☐ Other (sp	pecify)	in Part I.			Mor	ibute to th	
been signed by the attending should be detached for use a	Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	1□Live birth 2 4□Pregnant at t 9□Unknown	2 Fetal death time of death	5 ☐ Other (sp	pecify)	in Part I.	_		Mor 2 I No 24b. W	ibute to th	Day Year le cause of death? ably 4 Unknown csy findings availat inpletion of cause of
been signed by the attending should be detached for use a	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of the conditions of	1 Live birth 2 4 Pregnant at t 9 Unknown ontributing to death bu	2 Fetal death time of death	5 ☐ Other (s _p	ause given	26. Place of	1 Death (Cha	1 Yes 24a. Was an autopsy performe 1 Yes 2	Mor 2 No 24b. W	ibute to the state of the state	Day Year le cause of death? ably 4 Unkno by findings availa inpletion of cause of
After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions of t	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown ontributing to death but Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day)	2 Fetal death time of death it not resulting in	5 ☐ Other (sp	ause given A Other. 8c. Injury a Work?	26. Place of 4 ☐ Nursir	Death (Che	1 Yes 24a. Was an autopsy performed Yes 2	Mor 2 INo 24b. W 17 d 10 11	ibute to the state of the state	Day Year le cause of death? ably 4 Unknow say findings availate impletion of cause of 2 No
forcy. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 Fetal death time of death time of death time of death at not resulting in the control of the c	tpatient 3 DC	ause given A Other: Bc. Injury a Work? 1 □ Ye	26. Place of 4 ☐ Nursin ut es 2 ☐ No	Death (Cheng Home 28d. [1 Yes 24a. Was an autopsy performer Yes 2 Geck only one) 5 Residence Describe how ocation (Stree	More coourse control 2 1 No 24b. Who 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ibute to the structure of the structure	Day Year The cause of death?
Throus are of order. The standard Directors After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physical	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. ysician: To the best of injer: On the basis of a light of the part of	2 Fetal death time of death time of death time of death at not resulting in the control of the c	tpatient 3 DO	ause given A Other. Bc. Injury a Work? 1 Ye	26. Place of 4 Nursin It Is 2 No	Death (Cheng Home 28d. I	1 Yes 24a. Was an autopsy performe. Yes 2 eck only one) 5 Residence Describe how coation (Stree Sity or Town, Street Sity or Town, S	Mor 20 use contr 24b. W 17 of 18 6 20 the injury occurre	ibute to the street of the str	Day Year The cause of death?
Funderal Directors. After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use a	Tedical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 Fetal death time of death time of death time of death at not resulting in the control of the c	tpatient 3 DO	ause given A Other. Bc. Injury a Work? 1 Ye	26. Place of 4 □ Nursin It Is 2 □ No In date and position, death of	Death (Cheng Home 28d. I	1 Yes 24a. Was an autopsy performed autopsy per	Mor 20 use contr 24b. W 17 of 18 6 20 the injury occurre	ibute to the state of the state	Day Year The cause of death?
beau. The funeral director, page 2 should be detached for use a	Tedical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. ysician: To the best of injer: On the basis of a light of the part of	2 Fetal death time of death time of death time of death at not resulting in the control of the c	tpatient 3 DO	ause given A Other. Bc. Injury a Work? 1 Ye 7, office at the time, in my opin	26. Place of 4 □ Nursin It Is 2 □ No In date and position, death of	Death (Cheng Home 28d. I	1 Yes 24a. Was an autopsy performed autopsy per	More 20 use control 2 4b. World 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ibute to the state of the state	Day Year The cause of death?

				1- State of Maryland / Department of Health and Certificate of Death	Mental Hy	200	5 03321
			j	Decedent's Name (First, Middle, Last)	2. Date of D	Reg. Nor U	3. Time of Death
		Physic /Medi		Woodrow Wilson Wright Jr.	Month Februa		oar M
		Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oea		4c. County of I	
				Harford Memorial Hospital Havre De		Harford	
	П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		irth 9. Pay, Year)	Birthplace (State or Foreign Country)
				215 – 42 – 5619	01/14	/1944 MD	
		nyland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		Ba-1 s	Director	MD Harford Havre De Grace			1 □ Yes 2 No
		vith th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	t Country?
		death with the Maryland ms 23a or 28a-f show	eral	125 N. Stokes Street 21078 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (USA	
	(0	fter d r Itam iner	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 X yes 2 No	(Specify Yes or Nerto Rican, etc.)		American Indian, Vhite, etc.
2	21215-0036	within 72 hours after ene. than "natural", or Ita	by	3 ☐ Widowed 4 Divorced If Ves. Give Year or Dates: 1960-1964		Specify:	nite
a	5-0	72 ho 'natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation (Give kind of work done during most of wo	orkina	16b. Kind of Busin	
8	121	within one.	mp	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	ong	Health Ca	ire
63		filed Hygie Hygie othar I		2 Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First Middle	, Maiden Sumame)	
0	an	ld be ental ked o	To Be		Lee Richa	,	
	Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Manatic evant.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			re, Zip Code)
10		es 1 and 2 of Health a f Itam 27 is r othar trai		Robert Wright Brother 2362 Shuresville Road			
9	ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	
8	Baltimore,	. Pages tment of I tant: If Its		`4 Donation 5 Other (Specify) Chesapeake Crematory	Feb 3 2005	Beltsville	e, Maryland
2	Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. It Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee M 10986 22. Name and Address of Facility Cremation and Funer	al Alter	natives	
				23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	Drive	Baltimore,	Approximate
	M	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition))		Interval Between Onset and Death
		/Medical		resulting in death) Due to (or as a consequence of):	y nano	mmel	
		Examiner	_	Sequentially list conditions. b			
		ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	. 0		
	_6	xecut and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)	1 le	ver	
	8760,	cate be executed physician and the burial-transit	dical E				
d	9	tificat ng phy as th	ledi				
1	Вох	ires that the death certific signed by the attending p d be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	
.05	O.	ne death the atten hed for u	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		Month	Day Year
X	Д.	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did t	obacco uso contribut	to the cause of death?
3	ds,	uires sign	d by	S and a second to contain the disconting in the discontinuing cause given in rait i.			Probably 4 Unknown
	Record	w requir been si should	ompleted		24a. Was		
3	Re	The la te has age 2	omp		autor	psy prior death	autopsy findings available to completion of cause of ?
OOD ROW	of Vital	ian: rtifical stor, p	e C	25. Was case referred to medical 26. Place of De.	1 ☐ Yes ath (Check only o	2 No 1 Y	es 2 No
0) t	hysic his ce I direc	To B	Hospital:		dence 6 Other (S	pecify)
00	0 0	ing Pl	4.4	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?		how injury occurred	,
7	Sio	ftand death tor: / the fi	catl	2 Accident investigation M 1 Yes 2 No			
	Division	l or A after Dirac	ertification	4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox	Street and Number or wn, State)	Rural Route Number,
		To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Salc	29a. Certifier (Check only (Ch	e, and due to the	cause(s) and manner	as stated.
		the Hein 24 tha Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	urred at the time,	date and place, and o	ue to the cause(s)
		With To	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
			N	00000		2/1/0	7.
		13	8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORMO-S. NOW, M.D. 601. Solubly Line	nion av	e Advas	S legace mo 10 %
		Sta	te	31. Date filed (Month, Day, Fear) 32. Registrar's Signature		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- /-
		Registr	ar	FEB 0 4 2005 Recor Is Specific			
	DHI	MH 17 Rev 1/20	01	- 2003 page of the			
				ORIGINAL			

		4	State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Registrar	rtment of Health and M 10, 2-15-05 tas tificate of Death	ental Hygien	2005 03322
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month January 3	3. Time of Death
	Physicia /Medic		Chung Kit Yu	the City Town and province of Dooth		0', 2005 8:45 A.M
	Examin	er	4a. Facility Name (If not institution, give street and number) 8704-35th Avenue	4b. City, Town, or Location of Death College Park		Prince George
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 099-54-9364 12□ F 54 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 7/6/1950	9. Birthplace (State or Foreign Country) China
			Usual Residence of Decedent			
	arylan show	_	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits M☐ Yes 2 ☐ No
	8a-f	Director	MD Prince George College 10e. Street and Number	Park 10f. Zip Code	10a (Citizen of What Country?
	with f	급	8704–35th Avenue	20740		USA
	death	Funerai		Was Decedent of Hispanic Origin? (Spet Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "nature!", or Items 23e or 28e-f show any injury or other treumatic event, Ite Modical Examinar must be notified at ance.	by	1 News Married 2 Warried 1 TVes 2 TWO	1 Yes 2 No Specify:	ricall, etc./	Specify: Asian
9	72 hou	ted		dent's Usual Occupation kind of work done during most of work!	ng 16b.	Kind of Business/Industry
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Che	DO NOT use retired)		Restaurant
Baltimore, Maryland 21215-0036	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last) (Unavailable) Yu	18. Mother's Name Cheung V	(First, Middle, Maide	en Sumame)
2	should be f and Mental h s marked ol	ဥ		ng Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip Code)
Z	is 1 and 2 soft Health ar Item 27 is other treu		/) =	4 35th Avenue, Col	lege Park	, Maryland 20740
ore,	es 1 a of Hei f Item r othe			matory or other place)		Location - City or Town, State
Ĕ	Page ment ent: I		'4 □Donation 5 □ Other (Specify) Geo. Was	hington Cem. 2/3/0		delphi, Maryland
Balt	Depart Depart Import any in					al Home, Inc. el, Maryland 20707
	Physician		23a (Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cross on each line. Immediate Cause (Final disease or condition a	er the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence oi):	O		/
	AND EDGE	Jer	Sequentially list conditions, if any, leading to financially cause. Enter Underlying Cause (Disease or injury			
	acuted ind transit	Examiner	that initiated events c.			
8760,	ate be executed hysician and the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):			
687	physics the s	edicai	d			
Box	that the death certificate be executed to by the attending physician and detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	w requires that fhe been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records,	has has	Completed			24a. Was an autopsy performed;	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
ita	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?		h (Check only one)	
of V	d is	2	1 ☐ Yes 2 No Pospital. 1 ☐ Inpatient 2 ☐ ER/Outpatien	The second secon	me 5 X Residence	6 □Other (Specify)
ou c	ding F	ion:	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe new ii	ijaly ossalied
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide Accident Investigation Suicide Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_	Hospitel	edical Ce	29a. Certifier (Check only one) Medicel Exeminer: On the basis of examination and/or in and marrier stated.	th occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
\	To the within 2 To the comple	Me	29b. Signature And title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
,	1)2		30. Name and address of person who completed cause of death (ttem 23a) (Type.	Print) Aug 4277	2-11015	Chang Wing 1900
		atė	31. Date filed (Month, Day, Year) FEB 0 4 2005	orgia 114271,	OTIVEY -	The state of the s
	Regist	rar	I ED U # ZUUD JOSEP JOSEP			

		í	For State Registrar	State of M		epartment of		and Mental Hy	giene Reg. No. 2005	03323
	Physicia /Medic	al	Decedent's Name (First, Middle, Irene Sarah Zel Aa. Fecility Name (If not institution, g	lner		4h City Town	n, or Location o	2. Date of De Month ROBUAL	ath Day Year	
	Examin Funeral	er	36 Cypress Driv	e . Sex 7. Ag	ge (In yrs. last birth	Nort	h East		Cecil	nplace (Stete or Foreign
	Director		198 07 6634 Usual Residence of Decedent 10a. State 10b. County	1□M 2\QF {	10c. City, Town		ys Hours	oct.5,		nsylvania 10d. Inside City Limits
	the Maryla 28a-f shor	ector	Maryland Cecil 10e. Street and Number			rth East	la .		10g. Citizen of What Co	1 □ Yes 2 💆 No
	ath with s 23a or	Funeral Director	36 Cypress Drive			2	1901		USA	
9800	72 hours after death with the Maryland neturel', or llems 23s or 28s-1 show deat Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1	,	13. Was Decedent of If Yes, specify C		gin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	decedent's Usual Oc Give kind of work do ife. DO NOT use re HouseWife	ne during most tired)	t of working	16b. Kind of Business/I	ndustry
yland	should be filed nd Mental Hygis marked other umatic event, II	e	17. Father's Name (First, Middle, La Alvin Snyder	st)				er's Name (First, Middle) Lie Semmel	Maiden Sumame)	
	od 2 shoulth and 27 Is m		19a. Informant's Name/Relationship Sandra Scott (Da			-			er, City or Town, State, Z Maryland 21	
nore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spe			Disposition (Name of crematory or other)		Date 2/5/2005	20c. Location - City or Bel Air, Man	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic		ko,	22. Name and Ad Bruzdzin	dress of Facilit	neral Home	·	_
8760,	Physician of Medical Examiner the privar-transit the privar-transit the privar-transit the privar-transit the privar-transit the privary that the privary transit the privary transit the privary transit the privary transit the privary transit tra	dicai Examiner	23a. Pani. Enter the disease, or or swork, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as b Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c Due to (or as c	HYPox	CIA TATIC		N CANCEK		Approximate Interval Between Onset and Death
O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death	3 ☐ Ectopic pregna 5 ☐ Other (specify,			23d. Date of delin Month	very Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant condition:	s contributing to death t	out not resulting in t	he underlying cause	given in Part I.		obacco use contribute to	
Vital Records,	The law ate has b page 2 s	Completed						1 ☐ Yes	prior to death? 2 No 1 Yes	opsy findings available ompletion of cause of
of Vit	Si Si	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpati		attent 3000	0.1	of Death (Check only or rsing Home 5 Residual)	one) dence 6 □Other <i>(Spec</i>	ify)
Division o	tending death. tor: After the funes	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	be 390 Place of In		iry /	njury at Work? I ☐ Yes 2 ☐ I	No	now injury occurred Street and Number or Rui	ral Pouto Number
Div	itel or Attenurs after deatlurs Director:		4 Homicide determine	building, e	tc. (Specify)			City or Tox	vn, State)	
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	fedical	(Check only 2 Medical Ex	Physicien: To the best aminer: On the basis of and manner st	of examination and/	or investigation, in m	ny opinion, dea	th occurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
)	To To	Σ	29b. Signature and title of certifier	your M.V.	2		ense number		Febuary	
			30. Name and address of person when 207 NOR TN	so completed cause of	death (Item 23a) (T	ype, Print) Tho	MAS M.	3/ DUGGAN, M 11921	D.	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 4	20 0	r's Signature			, , , ,		

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of rtificate of				jiene,	2005	033	324
	Physici		1. Decedent's Name (First, Middle, John Stanley						Date of Dea Month	th Day	Year 2005	3. Time of E	0
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town,	or Location	of Death	1		County of Death	11.20	
		Ψ.	FRANKLIN SQUAR	E HOSPITAL	CENTER		EDALE				BALTIMO	RE	
	Funeral		,	. Sex 7. A 1 ■ M 2 □ F	ge (In yrs. last birthday	Months Days		24 Hrs. 8. (Date of Birth Month, Day 0 / 1 9	/ 191	9. Birth	place (State or ntry)	Foreign
	Director		213-14-3040 Usual Residence of Decedent		85 Yrs.				0/19/	191	9 Mary	rand	
	how		10a. State 10b. County		10c. City, Town or L	ocation						10d. fnside City	
	88-f s	cto	Maryland Balt	imore	Colgate							1 🗌 Yes 2	2 XNo
	with the	Dire	10e. Street and Number			10f. Zip Code					en of What Cou	,	
	seath ms 23	Funeral Director	7753 Wynbrook 11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	21224 Was Decedent of	Hispanic Ori	igin? (Specify	Yes or No-		ed Sta 4. Race - Ameri		
9	or Ite		1 Never Married 2 Married	Armed Forces 1 1 Yes 2 1 1 Yes, Give	6?	If Yes, specify Cu 1 ☐ Yes 2 ☑ No	ban, Mexicar	n, Puerto Rica	n, etc.)		Black, White,	etc.	
93	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jiest Exactified of the Calified at	d by	3 Widowed 4 □ Divorced	Year or Dates	*****							nite	
215-0036	in 72 n "nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Occu is kind of work done DO NOT use retir	ipation e during mos ed)	t of working		16b. Kin	d of Business/In	dustry	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4o		ut Man				Def	ense		
Maryland 21	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	,	_			er's Name (Fir			·		
Z	d Men narke	To	John Zmijewsk 19a. Informant's Name/Relationship		10b Mail	ing Address (Stree		ania				- Co to	
Ma	id 2 si Ith an 27 is r		Paul Zmijewsk			3 Wynbr				-			2122
<u>, je</u>	of Hea		20a. Method of Disposition		20b. Place of Disp	The state of the s	1	Date			ation - City or To		
Ē	Page ment c ent: If ury or		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		Holy Ro			y 2/7	/05 E	Balt	imore,	Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23e or 28a-1 show any injury or other treumatic event, it's Medical Exercities must be notified at Once.		21. Signature on Funeral Service Lin	har	D 2	2. Name and Addi A Vid J. 01 Sout	webe Webe h Che	r Fun	eral Stree	Homet B	nes P.A Baltimo	re,MD	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause mly one cause on each	ed the death. Do not en line.	ter the mode of dy	ring, such as	cardiac or res	spiratory arre	est, 21	231	Approximate Interval Betwee Onset and De	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEPS									
	Examiner				s a consequence of):	LOMA							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Linter Unionlying Cause (Disease or injury		s a consequence of):								
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):								
8760,	cate be executed physicien and the burial-transit			d d	2 2 3 3 1 3 4 3 1 1 3 1 7 1								
9	certificate nding phy use as the	ledic		0.						-72,026			
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth		⊒Ectopic pregnan	су			23	3d. Date of defive	ery Day Ye	
0.	0 0	Physician/Medical	1 Yes 2 No	4□Pregnant 9□Unknown	at time of death 5	Other (specify)					MORE	Day 16	ai
۵	requires that the de een signed by the a nould be detached f	by Ph	Part If, Dther significant condition	s contributing to death	but not resulting in the	underlying cause g	ıven in Part I		23e. Did tob	pacco us	e contribute to t	ne cause of dea	ath?
Records,	w requires been sign should be	ed b							1 🗌 Ye	es 2 🏋	No 3□ Prot	ably 4 □Uni	known
eco	aw as b	Completed						/	24a. Was a autops	v	24b. Were auto	psy findings ava	ailable
E B	10 L	Con							perform	ned? 2 🛣 No	death? 1 ☐ Yes	2 No	
of Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			thon	of Death (Ch					
of		1: To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of In	tient 2 ER/Outpatie	of 28c. Inju	ary at		Describe ho		Other (Specification)	y)	
ion	Attending F r death. sctor: After by the funera	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Pay Year) Injury		ork? ∃Yes 2⊟	No					
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place of I	njury - At home, farm, s etc. (Specify)	reet, factory, office			Location (St. City or Town		Number or Rura	I Route Numbe) <i>r</i> ,
	Hospitel or the hours afte Funerel Dir tely filled in		29a. Certifier 1 💢 Certifying	Physician: To the bes	t of my knowledge, dea	th occurred at the	time date an	nd place, and o	due to the ca		ind manner as s	tated	
	ths Hos nin 24 h the Fur npletely	edical	(Check only 2 Medical Ex	aminer: On the basis and manner s	of examination and/or is	nvestigation, in my	opinion, dea	th occurred at	t the time, da	ate and p	place, and due to	the cause(s)	
	To the To the comp	M	29b. Signature and title of certifier	Meine	NA A	90	se number	-	2	9d. Date	signed (Month,	Day, Year)	
			1 Oh oli	1	()		5647	/		2 -	3-20	05	
/	3+1		30. Name and address of person with the control of	HINGER,	9000 FRANI	. Print) LLIH SQU	IARE !	DRIVE	, ISALT	IMOR	RE, MI	2123	7
	Sta	ite ar	31. Date filed (Month, Day, Year)	32. Regis	rar's Signature								

			1 - For State Registrar	State of Ma	arylanı	d / Depa <i>Cei</i>	artment rtificate	of H e of L	ealth a	and M		giene Reg. No.	005	033	125
	Physici /Medi		1. Decedent's Name (First, Middle, Las Geraldine M Z	iegel							2. Date of Dea	Day	2005 ^{Year}	3. Time of 7:15	Death A M
)	Examir		4a. Facility Name (If not institution, give 9604 Haven Farm 5. Social Security Number 6. Sr	Road Unit	t C		4b. City, 1 Perr	у На	Location of			4c. 6	County of Death altimore		
	Funeral Director		218 07 6191 1 Usual Residence of Decedent	°X M 2□ F 84		ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day August 6	/, Year)	9. Birthp Cour Balti	lace (State on htry) More, Mai	r Foreign ryland
	tha Maryla 28a-f shov	rector	Maryland Baltimore 10e. Street and Number			y Hall	ation	Code				10a Citia		0d. Inside Cit 1 ☐ Yes	•
	h with	i Di	9604 Haven Farm Road	Unit	С		2112					USA	en of What Coun	ury :	
920	d within 72 hours after death with tha Maryland jene. rr than "natural", or Itams 23a or 28a-f show the Madical Evarill with usite neithed at	by Funeral Director	11. Marital Status 1 M Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes XXIII If Yes, Give Year or Dates:		1		ent of His ty Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Americ Black, White, Specify: Whi	etc.	
Maryland 21215-0036	d within 72 jiene. r than "na Ite Medic	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5	j+)	16a. Deced (Give life. L	kind of work OO NOT use	done d	uring most	of worki	ing		od of Business/Indo		
/land	ba file tal Hyg d othe	To Be C	17. Father's Name (First, Middle, Last) Thomas Ziegel						18. Mothe Mary M		(First, Middle,			July	
	ss 1 and 2 should of Health and Men Item 27 la marka other traumatic.		19a. Informant's Name/Relationship (7 Patricia M. Freund	ype, Print)		19b. Mailin 922 5	g Address (Ramble	Street a	nd Numbe k Ro ad	r or Rum Bal	timore, M	r, City or laryla	Town, State, Zip	Code)	
Baltimore,	permit. Pages 1. Dep riment of He Important: If Iten any njury or oth		20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		20b. Pla ce Sacr	ace of Dispos metery, crem ed Hear	sition (Name natory or oth tof Je	e of ner place PSUS	Cem. F				ation - City or To		
Balt	permit. Departi Import any nj		21. Signature of Funeral/Service Licens	Chana	oki	7	Name and assahn 401 Bel	air I	Road R	altim	nne Md	21236			
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the classes or condition resulting in death) Sequentially list conditions,	aDue to (or as	consequ	ence of	er the mode Failu t car	of dying	, such as o	cardiac o	r respiratory arr	est,	~	Approximate Interval Betwo Onset and D	veen leath
8760,	icate ba exacutad physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a											
.O. Box 6	The law requires that the death certific tie has baen signed by the atlending p. vage 2 should be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1	2 Fetal o	death 3 🔲	Ectopic preç Other (spec					23	ld. Date of deliver Month I	-	ear
rds, P	w requires that baen signed t should be det	by	Part II. Other significant conditions co	ntributing to death bu	it not resul	ting in the un	derlying cau	ıse giver	n in Part I.		23e. Did tob	-	e contribute to the No 3 ☐ Proba	a cause of de	
		Completed									24a. Was an autops perform	у .	death?	sy findings av pletion of cau	
Vita	ysician: This contificate director, pag	Be	25. Was case referred to medical examiner?	lospital:						of Death	(Check only one	9)			
Division of	ng Ph ter th neral	atlon: To	1 Yes 2 No ' 27. Manner of Death Sanatural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	y 2	R/Outpatient 28b. Time of Injury		: Injury a Work?	4 □ Nur:	2	ne 5 X ⊢eside 8d. Describe ho		□Other <i>(Specify)</i> occurred		
Divis	ne Hospital or Attendir n 24 hours after death. te Funeral Director: Af eletely fillad in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	. (Specity)						City or Town	, State)	Number or Rural		97,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely fillad in by	ledical	one)	sician: To the best of ner: On the basis of and manner stat	examinatio	ledge, death on and/or inve	occurred at estigation, in	the time my opin	, date and nion, death	place, a occurre	nd due to the ca d at the time, da	use(s) ar ite and pl	nd manner as sta lace, and due to t	ted. he cause(s)	
	To To	Σ	29b. Signature and title of certifier	2				icense i		2	29	d. Date s	signed (Month, D		
1	01		30. Name and address of person who co	p eted cause of de	ath (Item 2	23a) (Type, P	rint)) (C	n	1.4 -	21204	<i>ا</i> ل .	Emmen.	31,20	70 5
	v '		31. Date filed (Month, Day, Year)	14D /505	OSC	Br.	bou	راد	1) /1	D o	21204		2.7		
	Stat Registra	-	FEB 04	32. Re mira 2000	Sugaratu Sugaratu	A.F.	1	3							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma		artment of F rtificate of I			Reg. No.	05	03326
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	V	3. Time of Death
	Physici /Medic		Dale Charles	Adams. Sr.				January	Day 7 22, 2	Year 005	1928 ™
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	ounau_j		ty of Death	
4	in.		Atlantic General			Berlin				ester	
	Funeral		5. Social Security Number 6. S	MAN OFF	(In yrs. last birthday) 7.1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		200-24-1644 Usual Residence of Decedent	X	74 Yrs.			October	20, 1930	Penn	sylvania
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Many Fe th	to	Maryland Worcest	er	Ocean Pin	00					1XYes 2□No
	h the	Director	10e. Street and Number	1	CCGGII P.III	10f. Zip Code			10g. Citizen o	What Coun	try?
	23a c	a D	101 Central Parke	East		21811			USA		
	r dea	neu	11. Marital Status	12. Was Decedent Ex Armed Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ita Medical Examinat must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XXX Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 □ Yes 2 X No	Specify:		Spec	ity:	Title of the
21215-0036	tural	edt	15. Decedent's E	<u> </u>	16a, Deced	dent's Usual Occup	ation	-	16b. Kind of	Business/Inc	White
15	nin 72 n "na Medik	Completed	(Specify only highest grant Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of work	ing			,
212	filed within Hygiene. other than "	mo.	12	2		Builder			Constr	uctio	a
	al Hy t other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,			•
Maryland	should be nd Mental marked c	은	Clarence Edward A	dams			Martha 1				
Nar	2 sho	1	19a. Informant's Name/Relationship				and Number or Run				Code)
e,	t and thealth		Dale Adams, Jr. 20a. Method of Disposition	(son)			Lane, Sal	Lisbury,	Mary L 20c. Location		21801
Baltimore,	permit. Pages 1 am Department of Heal Important: if Item 2 any injury or other once.		1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, cren		!			1886	
量	permit. Page Department. Important: it any injury o	- 4	* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Line	• •							, Maryland
Ba	Deparenti Importanti any ir	10	> KH P D	Server (FO		_	funeral Ho Hill Road				
· Spi	4 2		23a. Part1. Enter the disease, or com	plications that caused t	he death. Do not ent					arytai	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final			00					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	t Neck	Ch					
Н	Examiner		Sequentially list conditions		MINGM						
9	D =	Examiner	Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying	Due to (or as a	consequence of):						
	ecute and -trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for a la	consequence of):					-	
68760,	ficate be executed physician and is the burial-transit			200 (0 (0) 4 4	30/1304001100 01).						
387		edical		_ d							
Box (nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, nutcome o		-			23d. D	ate of delive	ry
	death cert e attendin ed for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti		Ectopic pregnancy Other (specify)	<u></u>		N	lonth	Day Year
Ö.	that the death certifed by the attending detached for use a	Physician/M	9 Unknown	9☐ Unknown							
S, P	The law requires that the title has been signed by thoage 2 should be detache	ру Р	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co		e cause of death?
ord	w requir been si should I	ted						1 🗆 Y	res 2□No	3 Prob	ably 4 □Unknown
ecc	elawr hasbe je 2 sh	Completed						24a. Was autop	ISV /	prior to con	osy findings available inpletion of cause of
===	: The cate h	Con						1 Yes	rmed? 2. No	death? 1 🗌 Yes	210 No
Vital Record	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat		The same of the sa		
of	Phys this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Mann of Death	1 Vinpatien			4 Nursing no	me 5 Resid		- ' ' '	")
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	and manner state	ed.						
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	10/19P	te	30. Name and address of person who Jeffrey A. Matzor 31. Date filed (Month, Pay, Yay)		ath (Item 23a) (Type, ranklin AV 's Signature	Print)		land 2	1811		

1/22/05 1928

Dale Adams 200-24-1644

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:42 M BROWN Blanche Dolores /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center timore Joseph Medical 8. Date of Birth (Month, Day, Year) Sept. 4, 1924 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min Mary Land 1 ☐ M 21公 F 80 Yrs. 215-64-0682 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show ?7 is marked other than "naturel", or items 23a or 28a-f shov treumatic event, it a Modical Examinst must be notified at 1⊠Yes 2□No Hagerstown Director Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 833 Lanvale Street U.S.A. Funerai filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Completed by white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than her own home homemaker 0 - 1018. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If item Z7 is marked oth any july or other treumatic event sone: Be John Henry Staubs A. Louise unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Brown, Sr. - son 19 Lehigh Avenue, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 26, 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Leitersburg Cemetery January Leitersburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 cons Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOGENIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed CARDIOMYOPATHY attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) detached cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒️No 24a. Was an certificate has autopsy 1 ☐ Yes 2 No Attending Physicien: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 DOA Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. After Injury 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D 24634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

TOWSON.

MARY_AND

DSLER

7601

32. Registrar's Signature

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M. D

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31. Date filed (Month, Day, Year) JAN 25

			For State		State of N	Maryland		artmen rtificate				lental Hy	Sept.		5	033	228
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	Physici				ESTA	ELIZA	ABETH	BLAU	UVEI	T		Month	Da		Year		
	/Medic Examir		4a. Facility Name (If not	institution, giv	re street and numbe	r)		4b. City,	Town, or	Location of	of Death	JAN.		20 County o		4:15	5 A ^M
			205 ST. 1							STE				CAR	ROL	L	
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	Examin	er	Kline Hospice House	4b. City, Town, or Location Mt. Ai			4c. County o	lerick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		r 24 Hrs.	8. Date of Birth		9. Birthplece (State or Foreign Country)
	Director		218-54-1182 1 56 Yrs.	Months Days Hours	Mill.	July 29,	1948	Maryland
	ow III		Usuaf Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			-	10d. Inside City Limits
	Mary Pe-f sh	tor	Maryland Carroll	Mt. Airy				1 ∑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of Wh	nat Country?
	e 23e		7 Watersville Rd.	2177				5.A.
_	iter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical	rigin? (Spe an, Puerto F	cify Yes or No- Rican, etc.)		- American Indian, White, etc.
3	ral', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2CX No Specify:	<i>/</i> :		Specify:	White
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D D	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Iteme 23e or 28e-f show event, if a Mudical Exertiral matter additional.	Be Co	17. Father's Name (First, Middle, Last)	•		(First, Middle, Ma		
Var		To B	G. Leroy Brown		Ne	llie Mar	ie Flem	ing
Maryland	ges 1 and 2 should tof Health and Men If Item 27 is marke or other traumatic			ling Address (Street and Number				
_	of Health Item 27		20a. Method of Disposition 20b. Place of Disp	etersville Rd.		t. Airy,		/1 ity or Town, State
ē	ages ent of ht: If It		1 ☑ Buriaf 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)				sboro, MD
saitimore,	permit. Pages 1 a Department of He Important: If Item eny injury or othe			22. Name and Address of Facili				
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	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or complications that caused the deeth. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as	s cardiac or	respiratory arres	t,	Approximate Interval Between Conset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	el lang	Can	ce/		diser and Death
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T T	The la ate ha page 3	Completed				autopsy performe	d?/ dea	or to completion of cause of ath?] Yes 2□ No
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DIVISION	nding th. : After e fune	ation	27. Manne of Death 1 ☑ Naturaf 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. fnjury at Work? M 1 Yes 2		8d. Describe how	mjury occurred	
2	er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	21	Bf. Location (Streenly or Town,		or Rural Route Number,
5	ital or irs aft ral Di							
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and page 2.	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	th occurred at the time, date an estigation, in my opinion, dea	nd place, ar ath occurred	nd due to the cau d at the time, date	se(s) and mann a and place, and	er as stated. I due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		29d	. Date signed (i	Month, Day, Year)
	WJL		A X AID	D 481	84		1118	105
	12		30. Name and address of person who completed cause of death (Item 23a) (Type ETHAMY ESKANDER; MD 50	Print) 7th C	tree	+ Fred	ericli	MD 2701
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7 37	, - '	1 . ~	- 11-6	
	Registra	-	JAN 1 9 2005 Kleen &	Societies.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Veronica Blaser Jan 2005 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Yrs 098-05-9750 **Director** 83 Aug. 30, 1921 Usual Residence of Decedent filed within 72 hours atter death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic evant, the Medical Examinar must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 X No Director 10e. Street and Number 1427 Cape St. Claire Road 10f. Zip Code 10g. Citizen of What Country? 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "ne any injury or other traumatic evant, Its Media once. Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Language & Reading Specialist School System 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Green Mary Ellen Barron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Blaser/Husband 1427 Cape St. Claire Rd., Annapolis, MD 21401 Jan. 21, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of uneral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 homes Alla 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last 4000000 Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Division of Vital Records. P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Xinpatient 2 ER/Outpatient 3 DOA Atter this 27. Manner of Death 28a. Date of njury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Teartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 0/17 2005 1)24804 MD lun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ame Annopolis terson 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 _ For State	State of I	Maryland					Mental Hygi	ene		
			Registrar 1. Decedent's Name (First, Middle	/ cotl	-	Ce	rtificate	of D	eath		g. No. 2	n c	0000
	Physic	ian								2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		George Alfor 4a. Facility Name (If not institution		na II	_	41 67: -				10 200		0416 M
	Examir	ner		, give street and number	,	atte	4b. City, To	own, or L SAU	ocation of Death		4c. County o	Death	1CI
	Funeral Director		5. Social Security Number 214–10–9347		Age (In yrs. la 87	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November	Year) 28,1917	9. Birthp Coun Maryl	lace (State or Foreign try) and
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	he M	ecto	Maryland Wicom 10e. Street and Number	ico	Fru	uitlan							1 XYes 2 No
	with with	ä	Toe. Street and Number				10f. Zip C	ode		10	g. Citizen of Wh	nat Coun	try?
	eath	era	830 Sharps Poin	t Road 12. Was Decede	nt Ever in 11 C	2 10 1	M D1	2182			USA		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the M. dical Examinational Legisland	by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Force	s? [] No	21	was Deceder f Yes, specify I ☐ Yes 2 X	Cuban,	Specify:	pecify Yes or No- Pican, etc.)	14. Race Black Specify:	, White, e	etc.
Ö	2 hou	ted	15. Decedent	's Education		16a. Deced	lent's Usual (Occupation	on	1	6b. Kind of Bus	Wh:	
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21	filed withi Hygiene. other than	E O	12	College (1-40	11 5+)	Railr	oad				Transpo	ortat	ion
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Maryland	should be nd Mental markad o umatic eve	To E	George Alford	Colonna, S	Sr.				Carrie			Dry	den
ar	2 sho and ! is ma		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (S	itreet and	d Number or Rui	ral Route Number,	City or Town, S		
	1 and 2 Health tem 27 i		George Alford C	olonna III	(son)	3913	West	Char	el Road	, Aberdee	en, mary	land	21001
Sre	ges 1 t of He If item or oth		20a. Method of Disposition	200	20b. Pla	ace of Dispo	sition (Name	of			C. Location - C		
altimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (Sp	3 ∐Removal from Sta pecify)_	(0)	•		, ,	Januar	v 21, 200)5 Sali	sbu	ry, Marylan
Balt	permit. Pages 1 a Department of Hec Important: If item any injury or otha		21. Signature of Funeral Service L	Member	CESP	22 H	Name and A	Address V Fu	of Facility Ineral H		ssional	Ass	sociation
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death.	Do not ente	or the mode o	f dying,	such as cardiac	or respiratory arres	t,		Approximate
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	/Medical		resulting in death)	Due to (or a	is a conseque	ence of):						-	
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٥.	that led b deta		Part II. Other significant condition	ns contributing to death	but not result	ting in the un	derlying caus	e given i	n Part I.	23e. Did toba	cco use contribu	ute to the	cause of death?
Records,	quires n sign	d by		·			, ,	3					bly 4 □Unkno wn
00	s been si should	ompleted								24a, Was an	24h Wa	ra auton	av findings quallable
	The lav	ш								autopsy	l pric	r to com	sy findings available pletion of cause of
of Vital		Ö	25. Was case referred to medical							1 ☐ Yes 2	1 No	Yes 2	!□ No
>	Physician: this certific ral director.	OB	examiner?	Hospital:	- 2 C	R/Outpatient	2 DO4	Other		(Check only one)			
		L'a	27. Manner of Death	28a. Date of In (Month, D	-	8b. Time of				me 5 Residence 28d. Describe how		Specify)	
Division	Attending F r death. ector: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	М	Injury at Work? 1 TYes	2 □ No		,,		
S	or Attendi after death. Director: A in by the fi	ifica	3 ☐ Suicide 6 ☐ Could no	and 286. Place of I	njury - At hom	ne, farm, stre	et, factory, of			28f. Location (Stree	at and Number	or Rural	Route Number
Ö	i Sir fe	ert	4 Homicide determin	building, e	etc. (Specify)					City or Town,	State)		nous or resimbor,
	Hospital 4 hours a Funeral tely filled		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowi	edge, death	occurred at the	ne time.	date and place.	and due to the caus	se(s) and mann	er as sta	red
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical	(Check only 2 Medical E	xaminer: On the basis and manner s	ot examinatio	n and/or invi	estigation, in	my opini	on, death occurr	ed at the time, date	and place, and	due to the	he cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	11/11/	2		29c. Li	cense nu			Date signed (A	Aonth, Di	ay, Year)
) (ph	11/11	Va-	0		D	252	09	1/:	211	7
	5mp		30. Name and address of personw	no completed cause of	death (Item 2	(Type, F	rint)	/	ST. 5	12/3 buh	n me	,	
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	Registra	ar	- WIND	2003	D 12	1. 150	3121						

Physician /Medical Examiner Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Medical Exeminer invative notified and once.

Baltimore, Maryland 21215-0036

Lewiscan

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital of within 24 hours at within 24 hours at To the Funeral Decompletely filled it completely filled it well call Ce

For State Registrar			ertificate of Health and I	Reg.	0000	03333
Decedent's Name (First, Middle, La	ast)		Timodio or Bodin	2. Date of Death	NO. U U J	3. Time of Death
Lewis Earl	Carr			Month	Day Year	9/0/3
4a. Facility Name (If not institution, give	ve street and number)	10 No	4b. City, Town, or Location of Death		4c. County of Deat	
5. Social Security Number 6. S	9/ ///(4////) Sex 7. Age (II	n yrs. last birthday	JALISDUM If Under 1 Year If Under 24 Hrs.	O Date of Birth	/	1/00
227-58-7905	1 M 2 □ F	65 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye October 20	, 1939 Vi	thplace (State or Fore buntry) rginia
Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation			10d. Inside City Lim
Maryland Wicomic	20	Hebron				1 X Yes 2 □
10e. Street and Number			10f. Zip Code	10g.	Citizen of What Co	ountry?
107 Whayland Driv	7e		21830		SA	
11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Eve Armed Forces?		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	
3 Widowed 4 Divorced	1 X Yes 2 □ No 7 If Yes, Give Year or Dates: 19	65–68	1 ☐ Yes 2 X No Specify:		Specify:	Mite
15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occupation e kind of work done during most of wor	king 16b	. Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)	rinoon A	wai au l bu	
17. Father's Name (First, Middle, Last	4+	DIOTO	gical Resource Eng	Ineer AC	gricultur den Sumame)	е
Charles Edward	Carr		Thelma		· ·	rumpler
19a. Informant's Name/Relationship ((Type, Print)	19b. Mail	ling Address (Street and Number or Ru	ral Route Number, Cit		
Meredythe N. Carr	c (wife)	107.1	Whayland Drive, Ue	bron, Mars	vland 21	830
20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	2	20b. Place of Disp	osition (Name of ematory or other place)		Location - City or	Town, State
`4 □Donation 5 □ Other (Special		Colosse Ba	ptist Church Cemetery	January 27, 3	2005 Walter	s, Virginia
21. Signature of Funeral Service Lice		2 3	2. Name and Address of Facility Holloway Funeral F	Home Profes	ssional A	ssociatio
23a. Part1. Enter the disease, or com	pplications that caused the	death. Do not en	501 Snow Hill Road	, Salisbu	ry, Maryl	and 2180
shock, or heart failure. List only			iter the mode of dying, such as cardiac	or respiratory arrest,		Approximate
Immediate Cause (Final	one cause on each line.		2)	or respiratory arrest,		Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	_ a		THE Mode of dying, such as cardiac	or respiratory arrest,	ACHYCARDIA	Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a co		2)	or respiratory arrest,		Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions	_ a	onsequence of):	2)	or respiratory arrest,		Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co	onsequence of):	CARDIAC ARRHYTHA SUDDEN CARD	or respiratory arrest,		Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions, if any, reading to intributate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	CARDIAC ARRHYTHA SUDDEN CARD	or respiratory arrest, $1/4S \qquad \qquad V-7$ $/AC \qquad DEA$		Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co	onsequence of):	CARDIAC ARRHYTHA SUDDEN CARD	or respiratory arrest, $1/4S \qquad \qquad V-7$ $/AC \qquad DEA$		Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions, if any, reading to intrinduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	CARDIAC ARRHYTHA SUDDEN CARD	or respiratory arrest, $1/4S \qquad \qquad V-7$ $/AC \qquad DEA$	TH -	Interval Between Onset and Death
disease or condition resulting in death) Sequentially list conditions, if any, reading to minimidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	onsequence of): onsequence of): onsequence of): onsequence of):	CARDIAC ARRHYTHA SIDDEN CARD HYPERTENSIVE M	or respiratory arrest, $1/4S \qquad \qquad V-7$ $/AC \qquad DEA$		Interval Between Onset and Death
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		-	For State Registrar	State of Ma	ryland / Depa	artment of H		, ,	ene 1. N2 () ()	15 6	12220
	ysicia	n	1. Decedent's Name (First, Middle, Last) Dorothy Mae Clem					2. Date of Death	Day 23	Y955	3. Time of Death 410 PM
	Medica kamine	r	A. Facility Name (If not institution, give s Fuhmey-Keedy	Nusing	Home	Bunso	Location of Death		4c. County of	linatol	n
	neral ector		5. Social Security Number 6. Sex 219-52-1279	7. Age	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Sept. 25,	ear) 1915	9. Birthplace Country) Mary1	
Maryland -f show	a pa		10a. State 10b. County		10c. City, Town or Lo						Inside City Limits
with the Marylar	in natifi	<u> </u>	faryland Washingto 10e. Street and Number	<u>n</u>	Hagerstown	10f. Zip Code		10g	. Citizen of W		
S 23a	Taust 1	- al	1175 Professional			21740			USA		
15-0036 15-20 A rate death w	injury or other traumatic event, If a Madical Exercitive rust be notified at a.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	 Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates: 	0	Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		- American k, White, etc. White	
15-00 in 72 hours	ledical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of worki	ng 16	b. Kind of Bus	siness/Indust	try
ire, Maryland 2121 is 1 and 2 should be filed within of Health and Mental Hygiens if Health and Mental Hygiens	Tal.	E C	Elementary/Secondary (0-12)	College (1-4or 5-	Homem			i _	Domesti	ic	
in de line de la company de la	event	g e	17. Father's Name (First, Middle, Last)					(First, Middle, Ma.		•	
Maryland d 2 should be fill the and Mental H. It hand Mental H. It	matic	0	Charles Morrison 19a. Informant's Name/Relationship (Type	oe Printl	19h Mailin	a Address (Street	Minnie and Number or Rura	Behern M			dol
, Ma and 2 s and 2 s ealth an	or trau		Brenda Albert/Daug	•			Road, Ha				de)
// () 0 ° -	or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispos cemetery, crem			-	c. Location - C		State
Baltimor Permit. Pages Department of it	jury o		* 4 ☐ Donation 5 ☐ Other (Specify)	2 Controlled	Rest Have	en Cemete	ry 1/26/	2005 Ha	gersto	wn, Ma	ryland
Balt Permit. Depart	any ir		21. Signatura Funeral Service Lice	1/5			ss of Facility Res ylvania A			_	
Physic			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused be cause on each line	the death. Do not ente					Ap	proximate perval Between present and Death
/Med Exam			resulting in death)	Due to (or as a	consequence of):	Failu	× 1				
77		Jer	Sequentially list conditions, if any, leading to immediate cause the body in the cause (Disease or injury	Due to (or as a	consequence of):	1 2714					
3760, ate be executed hysician and	the burial-transit	_	Cause (Disease or injury that initiated events resulting in death) Last	Duo to (or an a	20000000000 of						
8760, cate be ex				Due to (or as a	consequence of):						
687 tificate	as the	edic	a.								
I Records, P.O. Box 68 The law requires that the death certifics ate has been signed by the attending pl	detached for use as the	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopArs? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	P⊟Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	y Year
Cords, P	pe d	à	Part II. Other significant conditions conf	ributing to death bu	t not resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contrib		
Division of Vital Records, to Attending Physician: The law requires to after death.	CI I	Completed						24a. Was an autopsy performed	d2 pri	for to comple eath?	findings available ation of cause of
Vita Sician certifi	rector	ם ו	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death				
on of ding Phys	- F	OI : HOI	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatien 28a. Date of Injury (Month, Day		28c. Injury Work	4 Nursing Hon	ne 5 Residence 8d. Describe how i			
Divisio l or Attendi after death. Director: A	in by the	Ceruncation:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)			8f. Location (Stree City or Town, S		r or Rural Ro	oute Number,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	completely filled in by the		29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cien: To the best of er: On the basis of and manner state	f my knowledge, death	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and man and place, ar	ner as stated	1. cause(s)
To the within To the	comple		29b. Signature and title of certifier	and mainler state	Od.	29c. License			Date signed	(Month, Day,	, Year)
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1			1 1/11/1	NSHE	DWD	Print) 1126	oral	et, t	MB?	vste 217	40
Re	State gistra	-	31. Date filed (Month, Day, Year) JAN 2 5 200	32. Registrar	- //	che					

			1 - State Registrar Cel	artment of Health and Mental I rtificate of Death	Hygiene Reg. No. 2005 03334
Н	Physici	an	Decedent's Name (First, Middle, Last)	2. Date o Month	Day Year
	/Media		Francis H. Cowan	Janua	ary 19 2005 9:15 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			12102 Whiston Ct. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bowie If Under 1 Year If Under 24 Hrs. 8 Date of	Prince George's
	Funeral Director		049-10-0910 1\(\frac{1}{2}\) M 2 \(\text{F}\) 89 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month Dec.	f Birth (, Day, Year) 16,1915 9. Birthplace (State or Foreign Country) Vermont
	ould be filed within 72 hours atter death with the Maryland Mental Hygiene. arked other than "natural", or Items 23e or 28e-f show atte event. The Medical Exertifier must be notified at		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	a-fs	ctor	MD Prince George's Bowie		1 ☐ Yes 2 ☐ No
	or 28	Olre	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	should be filed within 72 hours atter death with the Marylan nd Mental Hyglene. marked othar than "natural", or Items 23a or 28a-f show imatic event. Ira Modical Experiment be notified a	Funeral Director	12102 Whiston Ct.	20715	USA
	r dea	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Amed Forces?	Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.
36	s atte , or li	by Fu	1 ☐ Never Married 2 ⚠ Married 1 ⚠ Yes 2 ☐ No	1 ☐ Yes 2 No Specify:	
ë	hour:	q p	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II		Specify:White
5	n 72 "nal	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	withi ene. than	щć	Elementary/Secondary (0-12) College (1-40r 5+)	nistrator	United Aircraft
0	filed Hygi othar ent. I		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	
au	ld be ental ked o	To Be	George L. Cowan	Jennie Bell	,
Maryland 21215-0036	should and Men s marke umatic	-		ng Address (Street and Number or Rural Route Nu	ımber, City or Town, State, Zip Code)
Ž	and 2 ealth a m 27 is			Whiston Ct. Bowie, I	
Baitimore,	- I a =		20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place) Jan. 21,	20c. Location - City or Town, State
Ĕ	Pages nent of ant: If it.		1 - Daniel 2 Molaniellon 3 - Italiana al notificata	tan Crematory 2005	Alexandria, VA.
ä	permit. Departr Imports any inju				uneral Home
<u> </u>	20 E 29		Chran bull 165		ie, MD. 20715
3/60,	Physician /Medical Examiner physician and physician and physician and the priral-transit	dical Examiner	23a. Part1. Enter the disease, or complications that cau_a_ the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):		ry arrest, Approximate Interval Between Onset and Death 5 years
O. BOX 6	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
ras, P	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un		olid tobacco use contribute to the cause of death?
VII ан жесого	s b	Completed		24a. W an p	Vas an utopsy erformed? 24b. Were autopsy findings available utopsy erformed?
<u>ra</u>		C	25. Was case referred to medical	1 ☐ Ye 26. Place of Death (Check on	
	Physician: this certitic ral director,	O B	examiner? 1 Yes 2 Oo Hospital: 1 Inpatient 2 ER/Outpatien	Othor	
on or	ding h. After tune	tlon: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		be how injury occurred
DIVISION	i gite	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	HO HO HO HO HO HO HO HO HO HO HO HO HO H	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and due to trestigation, in my opinion, death occurred at the tin	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the I within 2 To tha I complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			1 / Sallat my	D0052089	1/20/05
1.	V		30. Name and address of person who completed cause of death (Item 23a) (Type, It		
10				rmill Blvd. Suite 220	Gambrills, MD. 21054
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	E .	

			1_ For State	State of Maryland / Dep	artment of Health and I	•		•
			Registrar		rtificate of Death	Re	g. No. UU5	03335
	Physic /Medi		Decedent's Name (First, Middle, L. ALPHONSE FRANK	CALABRESE		2. Date of Death Month January	Day Yea	
	Exami	ner	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death		4c. County of De	ath
			4614 Amhurst Ro		College Park		Prince (
Ī.	Funeral Director			Sex 1 M 2 F 7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 14,	Year) (irthplace (State or Foreign Country) ew Jersey
	show)r	10a. State 10b. County	10c. City, Town or Le				10d. Inside City Limits
	the M	Funeral Director	Maryland Prince	George's College				1 X Yes 2 No
	with with	ģ		- 1	10f. Zip Code		g. Citizen of What (Country?
	death ms 23	lera	4614 Amhurst Ro		20740 Was Decedent of Hispanic Origin? (Sr	pacify Yas or No-	U.S.A.	nerican Indian
980	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or Items 23a or 28a-f show avent, I're Mydical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, Wh	
5	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation 16a. Dece	dent's Usual Occupation	ring 1	6b. Kind of Busines	
21215-0036	filed within Hygiene. Ithar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work DO NOT use retired) Senate Investigat		Federal C	overnment
ng	be filed tal Hygie d othar i	Bec	17. Father's Name (First, Middle, Las			e (First, Middle, M		over inheir c
yla	es 1 and 2 should be of Health and Mental f item 27 la marked o r othar traumatic ave	2	Frank Calabrese		Mary Dio			
Maryland	12 sh h and 7 la m traum		19a. Informant's Name/Relationship		ng Address (Street and Number or Rui			
	1 and Health em 27 thar tr		John F. Calabrese 20a. Method of Disposition	20b. Place of Dispo	Parallel Lane, Si			
Baltimore,			1 X Burial 2 ☐ Cremation 3	Removal from State cemetery, crer	matory or other place)		0c. Location - City o	
텵	는 문란 등		'4 □ Donation 5 □ Other (Special Sign Fre of Free Page 121. Sign Fre of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free of Free Page 21. Sign Free Of Free Page 21. Sign Free Page 21. Sign Free Of Free Page 21. Sign Free	, date of i	Heaven 1/21 Name and Address of Facility Gas	1/2005 S	ilver Spr	ing, Marylar
Ba	Depa Impo any ir		1/1/2/2		739 Baltimore Ave			
F.			232 Part1. Enter the disease, or com	plications that caused the death. Do not ent				Approximate
	Physician		Immediate Cause (Final disease or condition	Cardiac Ischemia				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Coronary Atherosc. Due to or as a consequence of	lerosis			
	uted d ansit	Examiner	Cause (Disease or injury	Hoerlipidemia				
o,	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,	e ys	lical		_ d				
89 x	ertifica Jing ph	/Mec	IF FEMALE:	20- 14			10	
O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year
<u> </u>	that t		Part II. Other significant conditions	contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds,	The taw requires that the the has been signed by the bage 2 should be detache	ed by	Diabetes Mell					robably 4 Unknown
Vital Record	aw require s been si s should i	ompleted	Chronic Kidne	v Disease		24a. Was an	24b. Were a	utopsy findings available
Ĭ	The tav cate has page 2 :	lmo				autopsy performe	prior to	completion of cause of
<u> </u>		BeC	25. Was case referred to medical		26. Place of Death	1 Yes 22 (Check only one)	No I LIYes	s 2□No
	S S	To E	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	04		ce 6 ☐Other (Spe	ecify)
ב כ	ding Phi h. After thi funeral		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury Injury		28d. Describe how		
20	Attanding r death. sctor: After by the fune	cat	2 Accident investigatio		M 1 ☐ Yes 2 ☐ No			
Division of	l or Attanater deatl	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Pt (Check only one)	sysician: To the best of my knowledge, death niner: On the basis of examination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Mont	
	->-0		> 11 S MAD	max a	D0051473		anuary 20	
سمارا	10		30. Name and address of person who	completed cause of death (Item 2 a Troop, F				, 2003
1	10		Kathy Brenneman		St. NE, #021, Was	hington,	DC 2001	7
	Sta		31. Date filed (Month, Day, Year)	Registrar's Signature	de la			

		For State Registrar	State of Maryland	Department of Health an Certificate of Death	d Mental Hygier	4000	03336
Physicia /Medic	n al	1. Decedent's Name (First, Middle, La. CRISTIAN	ANTHONY	DIAZ	January	27 2005	3. Time of Death
Examine Funeral Director		Aa. Facility Name (If not institution, give SHADY GROVE 5. Social Security Number 6. S	ADVENTIST HO	4b_City, Town, or Location of C SP. ROCKVILLE, birthday) If Under 1 Year If Under 24 Yrs. Months Rays Hours !	MARYLAND Hrs. 8. Date of Birth (Month. Day, Yes	4c. County of Death MONTG(9. Birth; ar) 2005 MF	OMERY Dilece (State or Foreign NRY LANN
77	'n	Usual Residence of Decedent 10a. State 10b. County		own or Location THERSBURG, MARY	LAND		0d. Inside City Limits 1 ▼Yes 2 □ No
809 SGAI	I Director	10e. Street and Number	GOMERY GAIT BIDE DRIVE	101. Zip Code 20878		Citizen of What Cour	
₹	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?, 1	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P Yes 2□ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White, Specify: WH	
BOY 01/25/0	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)		Sa. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b.	Kind of Business/In	dustry
7811 TELLON 5/05 M 0 8 08280	To Be C	17. Father's Name (First, Middle, Last) ERIC DIA 2 19a, Informant's Name/Relationship (2	18, Mother's YAN 16 9b. Mailing Address (Street and Number o	Name (First, Middle, Maid A D CAS	TELLON	TORRES
25707 CAST 01/25/4		YANIRA CASTELL 20a. Method of Disposition 1 □ Burial 2 Ocremation 3 □	ON MOTHER S	392 WEST S) of Disposition (Name of tery, crematory or other place)	DE DRIVE,	/3	BURG, MD
ದು ೩೭೯೩		4 Donation 5 Other (Specification of Fungral Service Licer	1) DIE	22. Name and Address of Facility	B 28,2005 <u>M</u> DVENTIST 99	ORGANTO	OWN, PA
Physician /Medical Examiner		23a. Part1. Enter the disease com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	o not enter the mode of dying, such as car emiq as of):		JOT PRESIDE	Approximate Interval Between Onset and Death
3760, ate be executed hysicien end ine buriel-frensit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	b. Sepsis Due to (or as a consequence Due to (or as a consequence d.	prematurity	<i>n</i>		24 hrs 24 hrs
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The lew requires that the death certific 49 hours effer deeth. Funeral Director: After this certificate has been signed by the attending piety filled in by the funeral director, page 2 should be detected for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dec 4 Pregnant at time of death 9 Unknown			23d. Date of delive Month	ory Day Year
cords, P	<u>ا</u> ھ	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause given in Part I.		ouse contribute to the	
Division of Vital Records, or attending Physician: The lew requires teller deeth. Director: After this cartificate has been signe in by the funeral director, page 2 should be a	Completed				24a. Was an autopsy performed?	24b. Were autoprior to condeath?	psy findings available apletion of cause of 2000
On of Vita	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No		Outpatient 3 DOA Other: 4 Nursin	Death (Check only one)		/)
ision (Attending F deeth. ctor: After y the funer	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in		
DIVIS	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, Sta		l Route Number,
DIVISION To the Hospital or Attention Wilhin 24 hours effer deal To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Cartifying Ph	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	lge, death occurred at the time, date and p and/or investigation, in my opinion, death o	ace, and due to the cause ccurred at the time, date a	(s) and manner as st ind place, and due to	ated. the cause(s)
To the within To the comp	W	29b. Signature and title of certifier	· M. D		_	Date signed (Month, Duary 2)	
		30. Name and address of person Who 911 Medico	Road Pr	ouxville MD	20850		
Stat Registra	-	31. Date filed (Month, Day, Year) FEB 0 4 2	32. Registrar's Signature	Sparle			

			For State	State of Maryla		artment of h			711115	03337
			Registrar 1. Decedent's Name (First, Middle, I	ast)		illicate of	Dealli	2. Date of Deal	eg. No.	3. Time of Death
ı	Physicia		Sarah Jane	Elliott				Month	Day Year	12:30 PM ^M
	/Medic		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Deatl	1	4c. County of Death	
	LAGITIAT		Peninsula lenin	nal Redical	10 nder	500	lishurd		Wicomi	
F	uneral				s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign untry)
Di	irector		214-30-7767	^{1□ M 2} √√F 74	Yrs.	WOITIS Days	FIOUIS WIII.	November !	5, 1930 Mary	land
and	I.		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
Maryl	f sho	ō			•					1 Tyes 2 XNo
death with the Maryland	28a	Director	Maryland Wicomi 10e. Street and Number	CO L	elmar	10f. Zip Code	_		0g. Citizen of What Cou	untry?
× ×	38 o	Ole	21075 Derming De	- 2		21875				
deat	sms i	Funeral	31975 Downing Ro	12. Was Decedent Ever in Armed Forces?	U.S. 13.		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	USA 14. Race - Amer	
affe o	or lite		1 Never Married 2X Married			1 ⊡Yes 2 X No		o rican, etc.)	Black, White	, etc.
5-UU36 72 hours after	rhan "natural", or items 23a or 28a-1 show the Medical Examination but the notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify:	White
72	"nat edice	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of wor d)	king	16b. Kind of Business/li	ndustry
within ene.	than the M	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		u)		Demosti	-
H H	other ent, I	a l	17. Father's Name (First, Middle, La	st)	nomen	gver	18. Mother's Nan	ne (First, Middle, I	Domestic Maiden Surname)	<u>c</u>
ylan ouid be Mental	rked tlc ev	To B	Roscoe		Purne]	.1	Flora		Bi	unting
ary short	s ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number	, City or Town, State, Zi	ip Code)
and 2	n 27		William Winston				ng Road,	Delmar,	Maryland :	21875
ore of H			20a. Method of Disposition 1X Burial 2 ☐ Cremation 3		Place of Dispo cemetery, cre-	osition (Name of matory or other pla	сө)	Date	20c. Location - City or T	own, State
Pages	injury o		`4 ☐ Donation 5 ☐ Other (Spec	(Pow	ellville	Cemetery J	mauary 24,	2005 Po	wellville, Mar	yland
SALTIMOFE, permit. Pages 1 a	Impor any in once.		21. Signature of Funeral Service Lic	enses	\circ	2. Name and Addre	Funeral I	lome Prof	essional A	ssociation
a a c	1 = 16 OI		Keil /	Cerrey (+)		01 Snow	Hill Road	l, Salish	oury, Maryla	and 21804
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de- ly one cause on each line.	ath. Do not en	er the mode of dying	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Sician		Immediate Cause (Final disease or condition resulting in death)	a. acute r	ena to	allure				Oriset and Death
	ledical aminer		A south of the sou	Due to (or as a conse						
		i i	Sequentially list conditions, if any, leading to immediate	b. ClyvhoS Due to (or as a conse						
rted	ansit	Examiner	Cause (Disease or injury							
о о о	ial-tr	Еха	that initiated events resulting in death) Last	Due to (or as a conse	equence of);					
OX 68 / 60, certificate be executed	physician and the burial-transit	dlcal		d						
D I	ng ph		IF FEMALE:							
death ce	been signed by the attending p should be detached for use as I	cian/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnanc	у		23d. Date of deliv	,
. 9	the a	/sici	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)	·		Month	Day Year
r in	ad by detac	Physi	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I	23e Did tob	pacco use contribute to	the cause of death?
dS,	sign d be	d by		,	, and a	noonying ozoso gn	TOTAL TOTAL TO			bably 4 Minknown
	been	ete								,
The law	has Je 2	ompleted						24a. Was a autops perform	y prior to co	opsy findings available ompletion of cause of
		e Co	25. Was case referred to medical				00 Pl (P		2 No 1 ☐ Yes	2 No
99		o B	examiner?	Hospital:	☐ ER/Outpatier	t 30 DOA D#		th (Check only on	e/ ence 6 □Other (Speci	4.1
T O L	두 급	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	197
DIVISION (all or Attending Faffer death.	tor: Af	ertification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	on	liquiy		Yes 2□No			
VIST Atte	Director: in by the	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, st	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,
Urs af	filled in by	O								
To the Hospital or A within 24 hours after	Fune tely fi	edical	(Check only 2 Medical Ex	Physician: To the best of my kill eminer: On the basis of examin	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as a ate and place, and due t	stated. to the cause(s)
othe c	To the Fun completely	Med	29b. Signature and fille of certifier	and manner stated.		29c Licens	se number	20	9d. Date signed (Month,	Day Year
⊬ 3	Q) [] [] []	Vas Ix		1110	659368	-	1/2.).	5
ĺ	111		30. Name and address of person wh	o completed cause of death (the	em 23a) (Tune	Print)			1120/6	
U	51,		John VISIOI	m. o.	100 E	MKL011	31.	SAL1564	in mo	
	Sta	te	31. Date filed (Month, Day, Year)	2005 32. Rigistrar's Sign	nature	1			ause(s) and manner as a ate and place, and due to get a signed (Month,	
	Registr	ar	JAN & 4	LUUJ MININE	D. Po	DENEL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year George Glenn Eatmon, Sr. January 18 2005 07:54 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Malcolm Grow Hospital Camp Springs Prince George 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. Director 243-50-1635 68 1937 North Carolina 6. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits or 28e-f show injury or other treumatic event, the Madical Exercities rout be rullified at Marvland Prince George Temple Hills 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 3809 25th Avenue 20748 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", or Ite Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sears & Roebuck Private 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Glenn Henry Eatmon Bobree Mozell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erdine F. Eatmon/Spouse 3809 25th Avenue, Temple Hills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 N Removal from State Cemetery Hill Enfield, N.C. * 4 ☐ Donation 5 ☐ Other (Specify) Jan.23,2005 21. Signature of Funeral Service Licenses 22. Name and Address of Facility once. anyi Alexander S. Pope Funeral Homes 101085 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 the attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate l Division of Vital 1 Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2√2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA 15 Inpatient After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and ttle of certifie 29c. License number 29d. Date signed (Month, Day, Year) MA aay son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Sadghian, M.D. 6130 Oxon Hill Rd., Oxon Hill, MD Iradj 20745 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			State of Maryland / Dep	partment of Health and Mental	•	0000
			1 - State Registrar C6 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. UU5	13339
ı	Physici /Medi		Zeno Melvin Fisher Jr	Mont		3. Time of Death 04 : 47 pm
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
8	Funeral	[P.6	5. Social Security Number 6. Sex 7. Ale (In yrs. last birthday	bakkmoze // If Under 1 Year If Under 24 Hrs. 8. Date	of Birth 9 Birthplac	ce (State or Foreign
	Director		214-46-9400 1 M 2 F 58 Yrs.	Months Days Hours Min. (Mon Feb	th, Day, Year) Country 07 1946	ce (State or Foreign MD
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		. Inside City Limits
	e Man 3e-f sh Iifiru	ctor	MD Carroll Westmi	inster		1 ☐ Yes 2√2 No
	with th	Dire	10e. Street and Number 6 601 North Bend Court	10f. Zip Code 21157	10g. Citizen of What Country USA	?
	be filed within 72 hours after death with the Maryland tal Hygiene. dothar than "natural", or flams 23c or 28e-f show event, if e Medical Exemires the multified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - American	
36	rs after	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White	
2-0036	72 houral	ted t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Indus	
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	I Hygie othari	a	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N		
Maryland		To B	Zeno M. Fisher Sr	Beatrice He		
Mar	# 12 B		The state of the s	ling Address (Street and Number or Rural Route I North Bend Court West	Number, City or Town, State, Zip Co minster, MD 211	
ore,	es 1 and of Health fitem 27 r other tu		20a. Method of Disposition 20b. Place of Disposition	position (Name of Date ematory or other place)	20c. Location - City or Town	
altimore,	Pag ment ant: t		'4 □ Donation 5 □ Other (Specify) Lake View	Memorial Pk 1/22/200	5 Sykesville, M	ID
Ba	Departr Imports any inj			rittsdrifterfillhome and 112 Washington Road We		1157
	-		23a. P. 11. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		ory arrest. A	oproximate terval Between
F	Physician /Medical	ŧ IJ	Immediate Cause (Final disease or condition resulting in death)	Encephalo pathy		nset and Death
	Examiner		Due to (or as a consequence of):	Attlotor de peu dus	+ 3016 124 for	
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ilure,	asjoi as ig	
,	execute n and ial-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	stoke	2	
8760	certificate be executed dring physician and ise as the burial-transit	licai		itrial fibrill	atton	
9 XO	certific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		224 Date of dalling	
m .	0 0 0	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Da	y Year
о. О	hat the de od by the detached			underhing source given in Red I	Did tobacco use contribute to the c	avec of death?
ecords,	law requires that the as been signed by th 2 should be detache	d by	0	ease,	1 ☐ Yes 2 ☐ No 3 ☐ Probably	
eco	law require as been si 2 should t	Completed	Severe mitral regue		Was an 24b. Were autopsy autopsy prior to comple	findings available etion of cause of
a E	sicien: The law certificate has t irector, page 2 s			pe 2 101	performed? death?	No
Vital	Physicien: rthis certifica ral director, p	o Be	examiner? 1 Yes 2 No Hospital: 1 Physiciant 2 FR/Outpatient	26. Place of Death (Check of them. 3 DOA Other: 4 Nursing Home 5	nnly one) Residence 6 □Other (Specify)	
n of	Vite	lon: T		of 28c. Injury at 28d. Desc Work?	ribe how injury occurred	
DIVISION	Attending ir death. actor: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, st	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Locat	ion (Street and Number or Rural Ro	oute Number.
ā	ital or irs afte ral Dire	Cert			r Town, State)	·
	To the Hospital or Attendi within 24 hours after death To the Funeral Diractor: <i>K</i> completely filed in by the fi	edica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to restigation, in my opinion, death occurred at the	the cause(s) and manner as state ime, date and place, and due to the	d. cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day	, Year)
	WIL		Hoisamy MD	2ES 000	January 17	, 2005
	16		30. Name and addr-ss of person who completed cause of death (Item 23a) (Type	Print) Loch leven Bl	ed Baltimo	21239
	Sta		31. Date filed (MoAth, Day, Year) 32. Registrar's Signature		1	
3	Registr	ar	JAN 1 9 2005 Bleen &	Societi s		

			For	State of Maryla				Mental Hyg	•	
			1 - State Registrar			rtificate c			g. No. 2005	03340
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	h Day Year	3. Time of Death
	/Media	al	SUSAN VIOLETTA	GRIMM	<u> </u>			JANUARY	22 2005	8:14 PM
П	Examir	ier	4a. Facility Name (If not institution, give FAHRNEY-KEEDY MEM)				n, or Location of De	eath	4c. County of Deati	
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Ye			WASHIN 9. Birth	nplace (State or Foreign untry)
	Director		219-20-2867	□M 200 F 91	Yrs.	Months Da	ys Hours M	in. (Month, Day, JAN. 17	1914 MA	RYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	ţo	MARYLAND WASHING	GTON		BOONS	SBORO			1 ☐ Yes 2 No
	ith the	by Funeral Director	10e. Street and Number			10f. Zip Cod		10	Og. Citizen of What Co	untry?
	ath w	ral	8507 MAPLEVILLE RO				21713		U.S.A	
	items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No	1 U.S. 13.	Was Decedent of f Yes, specify C	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Exercise must be nailified at	by F	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 1 ☑ 1	No Specify:		Specify:	HTTE
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Oc	cupation	vorkina	6b. Kind of Business/l	
121	within ene. then "	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of vitred)		TIDI TO DOAD	D OF ED
	e filed al Hygie othar vent, u		17. Father's Name (First, Middle, Last)		CAL	TITERIA	MANAGER 18. Mother's N	lame (First, Middle, M	UBLIC BOAR	D OF ED
lan	Aental Aental rkad tic ev	To Be	CHARLES EDGAR LESI	LIE			MAUDE	ELIZABETH	ROME	
Maryland	2 shoul and Ma is mari		19a, Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Str	eet and Number or	Rural Route Number,	City or Town, State, Z	p Code)
	1 and Health tam 27 other tr		VIRGINIA E. McCUSI					SPRING, MA		722
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	-	natory or other	place)		20c. Location - City or T	
텵	artme ortant injury		 4 □Donation 5 □Other (Specify) 21: Signature of Funeral Service Licens 				TERY O1 /			MARYLAND
Ba	Depa Depa Impo any ir		Kelly	A. Zimmerman	BA	ST FUNI	ERAL HOME		National o, Marylan	
		/	23a. Part. Enjerthe disease, or comp shock, or hear failure. List only of	_	eath. Do not ent	er the mode of	dying, such as card			Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	, Dementia						Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or as a cons						
		er	Sequentially list conditions, if any, leading to immediate	b. Parkinson Due to (or as a cons		ase				
	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•						
Ö,	ate be executed hysician and the burial-transit	Exe	resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	cate b physic the b	dlcal		d						
×6	death certifica e attending ph d for use as tl	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy				23d. Date of deliv	an.
. Box	death e atte	by Physician/Med	in the past 12 months?	1☐Live birth 2☐F 4☐Pregnant at time o		Ectopic pregna Other (specify)			Month	Day Year
P.O.	at the d by th etache	Phys	9 🗆 Unknown	9□ Unknown						
Ś	Physician: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the		Part II. Other significant conditions co	ntributing to death but not i	resulting in the ur	nderlying cause	given in Part I.		accoluse contribute to t s 2 □ No 3 □ Pro	
Division of Vital Record	w requ	Completed						24a. Was an	_	
Be.	he la e has age 2	шо						- autopsy perform	ed? prior to co	opsy findings available impletion of cause of
ital	ian: 1	BeC	25. Was case referred to medical				26. Place of D	eath (Check only one	PNo 1□Yes	2 No
<u>></u>	hyaic his ce	ို	TE TES PENO		☐ ER/Outpatien	t 3 DOA	Osh		nce 6 Other (Speci	(y)
o uc	ing P	lon;	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lr		28d. Describe how	v injury occurred	
isio	Attanding ir death. ector: Alter by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be 4 Hemiside determined	28e. Place of Injury - A	t home, farm, stre		Yes 2 No	28f. Location (Stre	eet and Number or Run	al Route Number
<u>S</u>	al or / s after of Dire	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	,,,		City or Town,	State)	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only 2 Medicel Exami	sicien: To the best of my lener: On the basis of exam	nowledge, death	occurred at the	time, date and pla	ce, and due to the car	use(s) and manner as s	stated.
	To the within 2 To the Complet	Medical	29h. Signature and title of certifier	and manner stated.			ense number		d. Date signed (Month,	
	8 18 1		Darmel n	ruled						,
			30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, I	Print)	10370		January 24	, 2005
5	4-5		FARID	MURSH	ED.	1126	shal c	t. Hoge	rstown in	D 21740
łs.	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 20	32. Registrar's Sig	gnature	and s		-	January 24 rstown M	
	negisti	(a)	-1115 W W W	J. 30 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	See But But	WONE OF STREET				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. U U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Ann I. Gentile January 22, 6:22 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Lintnicum

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Min. | Dec. 24 Linthicum Anne Arundel 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Year) 1918 1 □ M 2 🕏 F Illinois 337-01-4464 Yrs Director 86 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Md. Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 2607 Chapel Lake Drive #206 21054 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Business woman Ratail clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental and Mental Nicholis Gaglione Mary LaGreca 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Joseph Candella - son 2607 Chapel Lake Drive, Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 01 - 27 - 05St. Marys Cemetery Chicago, Illinois * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen ce Licens 22. Name and Address of Facility Beall Funeral Home 6215 N.W. Crain Hwy., Dowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastanic 12 yrs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s certificate has 1 Yes 2 No director 25. Was case referred to predical 26. Place of Death (Check only one) examiner Other: P 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑Other (Specify) Hospice his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred House To the Hospital or Attending 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifier Medical mpletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. 2401 Brandermi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20°, 2005 **Physician** January Bernard William Glorius, Jr. 5:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Aug. 26, 1938 Washington DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 579-46-8870 Director 66 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f ehow ner pust be notified at 1 Yes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4521A Ratcliff Place 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1956-59 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: δ 3 ☐ Widowed 4 🏌 Divorced al Hygiene.
d other then "natural
event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard William Glorius, Sr. Mary Catherine Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 i Kim Burtch - Daughter 12710 Norwood Drive, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 1 Buriai 2 Cremation 3 Removal from State permit. Pege Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cem 1-28-05 Cheltenham, MD 22. Name and Address of Facility
Huntt Funeral Home
P. U. Box 156, Waldorf, MD 20604-0156 21. Signature of Funeral Service Licensee M00053 auc J. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ARTERIOSCIENOTIC GARDIO VASCULAD Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print) LINE CENTER WALDERF, MIC 20602 12070 CLI) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

		For State		State of Ma	aryland				nd Men	ntal Hygid	ene	0.5	001	01.0
	Ti-	1 - State Registrar 1. Decedent's Name (First, M	iddle, Last)	1 0		Cen	ificate of	Death	2.1	Req Date of Death	g. No:	UJ	3. Time of	J 4 J
Physi /Med		ISARELI	E	A.6	KE	EN				Month WAR	Day 18	Zco5	12:5	_
Exam		4a. Facility Name (If not instit	ntion, give s	treet and number)	יתו	C'T> N/	4b. City, Town, o	r Location of	Death		rc. Gounty	et Peats	01	
Funera		5. Social Security Number	6. Sex	7. AQ	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	4 Hrs. 8.1	Date of Birth	Cr	9. Birthol	ace (State)	or Foreian
Directo		220-01-5346		M 20 X F	9		Months Days	Hours	Min.	Date of Birth (Month, Day,) pril 2	5,1912	Mar	lace (State of try) y land	
land wo		Usual Residence of Decedent 10a. State 10b. Con		arroll	10c. City	, Town or Loca	ation					10	0d. Inside C	ity Limits
a-f sh	ctor	MD Fre	der i e	k-	M	ount Ai	ry						1 ☐ Yes	2 🕱 No
death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number 4110 Waters	ville	Rd			10f. Zip Code	771		10	g. Citizen of V		try?	
Jeath v	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S	S. 13. W	as Decedent of H		n? (Specify	Yes or No-	U.S.A.	e - America	an Indian,	
after or its	þ	1 Never Married 2 3 Widowed 4 Divo		Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No		Yes, specify Cuba □Yes 2 X No	Specify:	Puerto Rica	ın, etc.)	Specify	k, White, e	ite	
2 2 3	Completed	15. Dece (Specify only hi	dent's Educ ghest grade	cation completed)		16a. Decede (Give ki	nt's Usual Occup nd of work done O NOT use retired	ation during most o	of working	11	6b. Kind of Bu	isiness/Ind	lustry	
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A 500 -	BeCc	17. Father's Name (First, Mic				nome	maker	18. Mother's	s Name (Fir	rst, Middle, Ma	Own h aiden Sumam			
aryland should be fill and Mental H marked oth	10	John Z. Rip	·							mmermar				
The day		19a. Informant's Name/Relat Rosalie Bri			hter		Address (Street							
S 1 and st Health Item 27 other tr	1	20a. Method of Disposition			20b. PI	ace of Disposi			Date		Oc. Location -			
Saltimore sernit. Pages 1. Department of He mportant: If Iten iny njury or oth		1 XBurial 2 Cremat 4 Donation 5 Othe	r (Specify)	emoval from State			Cemetery		/21/20		Taney			
Baltimor permit. Pages Department of Important: If Its	Succession	21. Signature of Furteral Ser	rice License). Wart	len		Name and Addres	•		tzler F ibertyt				
		23a. Part1. Enter the diseas shock, or heart failure.	e, or compli List only or	cations that cau	the death	. Do not enter	the mode of dyin	ng, such as ca	ardiac or res	spiratory arres	st,		Approximat Interval Bet Onset and	lween
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P #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	1	Due 🔭 (or 😘	a consequ	ence of):								
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. BOX b8/bU, death certificate be executed e attending physician and d for use as the buriat transit	Physician/Med	23b. Was decedent pregnan in the past 12 months?	2	3c. ff yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetaf	death 3 DE	ctopic pregnancy Other (specify)	1			23d. Dat Mor	e of deliver	,	Year
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On C Jing P After t funera	ion:	27. Manufer of Death 1 Natural 5 Pe		28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Injun Wor	yat k? Yes 2 ⊡ No	1	Describe how	v infury occurr	ed		
DIVISION t or Attending after death. Director: Atte	ificat	3 ☐ Suicide 6 ☐ Co	estigation uld not be termined	28e. Place of Inj	ury - At ho	me, farm, stree		165 2 140	28f.	Location (Stre	et and Numb	er or Rural	Route Nurr	nber,
tator rs afte al Dire	Certification:	4 Homicide		building, et	с. (Ѕреспу	")				City or Town,	State)			
DIVISION OF To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 Cert (Check only 2 Med one)	ifying Physical Exami	sician: To the best ner: On the basis o and manner st	t examinat	wledge, death i ion and/or inve	occurred at the tin stigation, in my o	ne, date and pinion, death	place, and occurred a	due to the cau t the time, dat	use(s) and ma e and place, a	nner as sta and due to	ated. the cause(s	s)
withi To t	Σ	29b. Signature and title of ce	rtifier (lendo			29c. Licens	3046	9	1	d. Date signed		Day, Year) Z Q Q	5
WIL		30 Name and address of an	enn who co	moleted cause of	leath (lea-	23a) /Tuna 17			1.01		enwary	- '	,	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 2005 Month **Physician** Olbrook 1930 An re/ma LOUISE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anchrage Nursing 5. Social Security Number 6. Sex Wicomice Sel15 6 If Under 1 Year | It Onder 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 19-34-2907 1 M 2 D F **Director** Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified as MD 1 ☐ Yes 2 No Be Completed by Funeral Director Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 28479 21853 Venton 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or itame 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BIACK 1 ☐ Yes 2 💢 No Specify: 3 Ø Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Do Mestic 2KGal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental Colon Shelley Jones White white 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28479 Venter Rd Date 20c. Location - City or Town, State Stir)1745 20b. Place of Disposition (Name of 20a. Method of Disposition 5 Burial 2 Commation 3 Removal from State 40. 1 Local Later St. Selis by 19, 100 21801 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESRA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed ASCUD Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 12 No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 4 hours after death Funerel Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check o ity one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1,20 /2005 D57952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Kilford ST. # 504B Soles 6 mg MD 21804 Babulal Das, MD. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JAN 2 5 Registrar

			For State Registrar			ryland / Dep <i>Ce</i>		t of H	lealth a	and M	lental Hyg	•	05	03345
			Decedent's Name (First, Mid	dle, Last)							2. Date of Dea			3. Time of Death
	Physici		Icie	Lee		Helmick					Jan 28	2005	Yeer	10:20AM M
	/Medic		4a. Facility Name (If not instituti				4b. City.	Town, or	Location of	of Death	oun 20	1	nty of Death	
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	Formand		5. Social Security Number	6. Sex	7. Age	(In yrs. last birthday)			If Under	24 Hrs.	8. Date of Birth			place (State or Foreign
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Maryland 21215-0036	shoul nd Me mari	Ĕ	19a. Informant's Name/Relatio)	19b. Mail	na Address	(Street a			al Route Number		n State Z	in Code)
S	d2sth arthart		Judith B. Dol				75, E	-			w Creek,		2674	
	1 an Heal am 2		20a. Method of Disposition	Ly, Daug		20b. Place of Disp cemetery, cre						20c. Locatio		
Baltimore,	agas ntof :: If it		1 X Burial 2 ☐ Cremation		rom State	I .				Fe	2005			
큹	it. Partmentrant	. 17	*4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service			Knobley M	emorta 2. Name an					New C		WV
Ba	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If itam 27 Ia markad other than "natural", or Items 23a or 28a-f show any njury or other traumatic avant, The Madical Examinating the natified at ODEs.		Para Service of Purietal Service	LAT	11	. '				Om	ith Fune urlingto		ome 267	10
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	West Con-		shock, or heart failure. L' Immediate Cause (Final	ist only one cause	on each line	9.								Interval Between Onset and Death
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ec	law lasb	npie									24a. Was a autops	sy	prior to c	topsy findings available ompletion of cause of
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<u>\S</u>	or Attendate death after death Director:	tific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	minod 286. I	Place of Injur	ry - At home, farm, s (Specify)	treet, factory	, office			28f. Location (Si City or Town	treet and Nu n. State)	mber or Ru	ra / Route Number,
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	the I the I the I	Med	one)	and	manner stat	ed.								
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			1 X C/		w				,					
			30. Name and address of person	on who completed	cause of de	ath (Item 23a) (Type	, Print)							
_			Paul Snow, M,		Med Ex	kam 124 W	3rd	St C	Cumber	rland	1 MD 215	02		
	Sta		31. Date filed (Month, Day, Ye	ar)		r's Signature								
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	Physici	an	Decedent's Name (First					31		2. Date of Dea Month	th Z U	Vear Year	3. Time of Death	
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	Examin	er	HON WALLA	DOISNA	of MU	_/	PONTE	46. City, Town,	or Location of Deat とれいるかけた			of Death	0	
	Funeral		5. Social Security Numbe		Sex		yrs. last birthday,	If Under 1 Year Months Days		8. Date of Birth (Month, Day 02-17-	1	9. Birtho	ace (State or Foreign	
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	viand ow			County		100	. City, Town or L	ocation				1	0d. Inside City Limits	
	a-fsh iffed	tor	MD	WICC	OMICO		PARSO	NSBURG					1X Yes 2 □ No	
	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?	
	s 23a		7480 MADELI	NE CIF					21849			JSA		
'	tter de	by Funeral	11. Marital Status 1 ☐ Never Married 2	. ☐ Married	12. Was Dec		in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Race Blac	e - Americ k, White,		
036	hours after death with the Maryland lural; or Itams 23a or 28a-f show at Examiner must be notified at		3 Widowed 4 □ D		If Yes, Gi Year or [ive **		1 ☐ Yes 2√∏ No	Specify:		Specify	: WH	ITE	
21215-0036	72 na	Completed	15. E (Specify on	ecedent's E ly highest gr	ducation ade completed))	16a. Dece	dent's Usual Occu	pation during most of wo	rking	16b. Kind of Bu	isiness/Ind	dustry	
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sio	an eath or:	cati	2 Accident	investigation	on			M 1	Yes 2 No					
Division	i te	Certification:	4 Homicide	determined	286. Plac	e of Injury ling, etc. (S)	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	∌r or Rura	Route Number,	
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	To the Hospital within 24 hours e To the Funeral Completely filled	edical	(Check only 2 1	fedical Exa	miner: On the b	pasis of examiner stated.	mination and/or in	vestigation, in my	opinion, death occu	irred at the time, d	late and place, a	and due to	the cause(s)	
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	20		RODNEY A.	A	Completed cau	se of death	(Item 23a) (Type,	Print)	5. 5	ALISBU	RY h	hD.	21804	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL NICOMICO SALISBUM Teninsula If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-30-1927 9. Birthplace (State or Foreign Country)
DE. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1XM 2□F 77 **Director** 221-16-6511 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "naturel", or Items 23a or 28e-f show treumatic event, the Medical Examinar must be multified at Director 1 ☐ Yes 2√☐ No Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30751 Dagsboro Rd. 21804 USA within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Polymer Technician Nylon Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H. lant: If itsm 27 is marked oth John W. Hearn Ethel Calloway Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda H. Hearn, Wife 30751 Dagsboro Road, Salisbury, Md. 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 Dother (Specify) Jan. 24, 2005 St. Stephens Cem. Delmar, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSIS /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached to Ö 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 10 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ■ npatient 2 □ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 3 DOA ō 28b. Time of Injury completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 34768

Registrar

State

ILH

2003 Register's Signature A Solisbury MD 21803

ss of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Wieland
31. Date filed (Month, Day Year) 2 4 2

			State of Maryland / Department of Health and M	Mental Hygie	2005 03348
			1 - State Registrar Certificate of Death 1. Degadent's Name (First, Middle, Last)	Reg	3. Time of Death
	Physici		CLIETAN JAMES HOLLAND	Month	Day Year 7,00 M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	4		SOI MAJE Hill Apt 364 SNOW Hill		WORCESTER
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birthplace (State or Foreign Country)
	Director		21640-4879 20 63 Yrs.	2-22	-41 MD
	and wo		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary -1 ehe	Į.	MD WORCESTER SNOW HILL		1 2 Yes 2 □ No
	r 28a	rec	10e. Street and Number 10f. Zip Code	109	J. Citizen of What Country?
	th witi	a D	501 MAPLE HILL APT. # 304 21863		USA
	ems er	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 ehow the Madigal Examiner marke ricitified at	by Fu	Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify: Pun is
1215-0036	hour tural	q pe	/ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	14	Bb. Kind of Business/Industry
5.	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ring	bb. Kind of business/industry
212	d with giene.	ШО	Elementary/Secondary (0-12) College (1-4or 5+) DISABLED		
	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	aiden Sumame)
<u>ylaı</u>	should b and Ments s marked umatic e	Tof	DENDIS EARL HOLLAND ANDREY	GILLE	T HOLLAND
Maryland	C1 00 = 0		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Addr ss (<i>Street and Number or Ruh</i>		City or Town, State, Zip Code)
	1 and Health em 27 ther to			ERLIN	Dc. Location - City or Town, State
JO.	Pages nent of I int: if it		18 Burial 2 Cremation 3 Removal from State	s 1 <	Control of town, state
Baltimore,	artme ortan injury	(21. Sign the real Service Licensee 22. Name and Address of Facility 23.	ENNIE	SMITH FIH
Ba	permit. Departr Imports any inj		Quel Tret 917-11 TSAREIL		ALISBURU. MD. 21861
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart third. List only one cause on each limb.		
	Pnysician:		Immediate Cause (Final disease or condition	mi	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):		
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	ed sit	ine	Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury	//.	
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E			
9	g phy as the	ledic			
Box	eath certific attending p	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	the att	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.0	that the dead by the detached	Phy	9 Unknown Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.	ODO Didasho	
S,	ires tha signed i	by	Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes	cco use contribute to the cause of death? 2 \notin no 3 \subseteq Probably 4 \subseteq Unknown
or	w require been signature should b	etec			
Records,	he law	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
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Jo (0 = 0	1=	27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	
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	To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only only) 20a. Certifier Check only only) 20a. Certifier Check only only 20a. Certifier Check only Check only Check only Check only Check only Check only Check only Check only Check only Check only Check only Check only Check only Check on	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	o the	Me	29b. Signature and title of certifier , 29c. License number	290	I. Date signed (Month, Day, Year)
	120		186 - 110 (Koz Klam D- (-2)	611	1/24/05
	200		30. Name and address of person who completed cause of death, (Ijem 23a) (Type, Print)	11	1 10-11
	12		Kazi S. Khan MD 13405. Division St. #301 Salisbury	md 218	104
	Sta		JAN 2 5 2005 32. Registrar's Signature		
	Regist	rar	JAN 2 5 2005 Blown & Sparke		

	1	- For Amend Item 5 Registrar		Cer	tificate d	of Death			03349
ysiciar		 Decedent's Name (First, Middle, Last,)				2. Date of De Month	aath Day Ye	3. Time of Death
Medica	I -	PAUL HEFFERNAN		-	41 02 T			y 19, 200	
amine	r '	Ia. Facility Name (If not institution, give	·			m, or Location of De	ath	4c. County of E	
orol		14Q Hillside Road 5. SocialSecurity Number 6. Sec		t birthday)	If Under 1 Y	nbelt Bar If Under 24 H	rs. 8. Date of Bir		George's Birthplace (State or Foreign
eral ctor		5. Social Security Number 137-30-1802 133-30-1802	M 2□F 66	Yrs.	Months Da	ays Hours Mi	n. 8. Date of Bir (Month, Da Jan. 1	ay, Year) 5, 1939 N	Birthplace (State or Foreig Country) EW Jersey
10.00	- I	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d Inside City Line
10 2									10d. Inside City Limit 1 X Yes 2 □ N
Director.	2	Maryland Prince Ge	eorge's Gree	nbe1t	10f. Zip Cod	10		10g. Citizen of Wha	
3	2	140 Hillside Road	1			0770	Ì	U.S.A.	Country
European Financial	<u> </u>		12. Was Decedent Ever in U.S.	13. V		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No		American Indian,
, F	2	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:			Suban, Mexican, Pue No Specify:	erto Rican, etc.)	Black, V Specify:	White, etc. White
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War I		Elementary/Secondary (0-12)	College (1-4or 5+)			one during most of w ntired)			
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9.6	ő							, Maiden Surname)	
To		Paul Heffernan 19a. Informant's Name/Relationship (Ty	roo Print)	10b Mailie	a Addraga (Ct	Margare		er, City or Town, Stat	a Tin Code l
treur								Visitorio	e, Zip Code)
any injury or other treumatic event, the Medical Examinar must be indiffed at once. To Be Completed by Europe Director		Constance McGann 20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name o	Avenue, Te	eaneck, N	J 07566 20c. Location - City	or Town, State
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any ir		Vallani A	MO13/7					uneral non	
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hy Physician/Madical	iyaicialiyi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3 🗆	Ectopic pregna Other (specify			23d. Date of Month	delivery Day Year
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actor actor	מ	25. Was case referred to medical examiner?	1 2. 1			_	eath (Check only o	one)	
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~ <u>*</u>	2	4 Homicide	building, etc. (Specify)				City or To	wn, State)	
o m o	<i>></i> ∟	29a. Certifier 1 \overline{\text{M}} Certifying Phys	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at th	e time, date and plac ny opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
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	Medical	(Check only 2 Medical Exami	7.6		D21	183	e 200 U	January 2	21, 2005

		í	1 - For State Registrar	State of Maryland	•	artmen					reg. No 0	05	03350
	Physicia /Medic Examin	al er	1. Decedent's Name (First, Middle, Las ETHEL MARIE IN 4a. Fecility Name (If not institution, give PENTER ULA REGIO	USLEY street and number) NAL MEDICAL		S	ALI	Location of	Death		Day 2005 4c. County WIC(OMIC	0
	Funeral Director		5. Social Security Number 220-01-2836 Usual Residence of Decedent	x 7. Age (In yrs. Ias ☐ M ②X☐ F 97	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2	Min.	8. Date of Birt (Month, Day 7/27/	1907	9. Birth Cou MD	place (State or Foreign ntry)
	death with the Maryland ms 23a or 28e-f show rmust be notified at	ector	10a. State 10b. County MD W1COM1CC	10c. City, 1	AJJV E		Code				10g. Citizen of		10d. Inside City Limits 1 Yes 2 No
036	n 72 hours after death with the Marylar "natural", or items 23a or 286-1 show calcal Evantrat must be notified at	by Funeral Director	20924 NANTICO National Status 1 Never Married 2 Married 3 Notation 4 Divorced	E ROAD 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		2	lent of Hi	<u> </u>	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	USF	ce - Ameri	can Indian,
N-612121	lled within 72 ho lygiene. her than "natura nt, the Medical in	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired	furing most (16b. Kind of B	ILS	,
Maryland	should be fi ind Mental H s marked otl umatic ever	To Be	17. Father's Name (First, Middle, Last) HOWARD C. M. 19a. Informant's Name/Relationship (7		19b. Maili	ng Address	(Street a	412	LIE	MAE	Maiden Sumar MESS r, City or Town	sick	o Code)
altimore, Ma	Pages 1 and 2 nent of Health a int: If Item 27 is iry or other trai		COATHALEEN HOPK 20a. Method of Disposition 1	Removal from State	etery, cre	BOX psition (Nam matory or of	ne of ther plac	31VA2	D	ate	21814 20c. Location BIVAL		
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licen		2	2. Name an	d Addres	s of Facility	ERAT		E 60 6	_	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ine cause on each line. a. Due to (or as a consequer	nce of):	ter the mod	e of dying	g, such as c	eardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Sacre
8760,	certificate be executed tring physician and ise as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequer d.	n Ø	c p Oc							
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Division of Vital	Attending Physician: The rideath. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man of Death 1 Natural 5 Pending investigation		VOutpatie 8b. Time o Injury		8c. Injury Work	er: 4 □ Nurs	sing Hon		ne) ence 6 ⊡Oti ow injury occur		fy)
Divis	Hospitel or Attend 24 hours after death Funeral Director: /	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)						City or Tow	n, State)		al Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Examone)	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, deat n and/or in	vestigation,	, in my or	ne, date and pinion, death a number	I place, a h occurre	d at the time,	ause(s) and m date and place, 29d. Date signe	and due t	o the cause(s)
	200		30. Name and address of person who	completed cause of death (Item 2	(3a) (Type,	Print)	DO	0599	131	1 -	1/21	105	·
	Sta Regist		30474 Mount V 31. Date filed (Month, Day, Year) JAN 2 4 2	completed cause of death (Item 2 LVN 32. Refistrar's Signatur 005	F EIN	bark	14	in	~(1)	11	153		

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** :300 M RALPH WILLIAM JONES 01 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO 3989 STOCKYARD ROAD EDEN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 XM 2 ☐ F Hours 83 Yrs. 04-21-1921 MARYLAND 218-12-1674 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director MD WICOMICO EDEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3989 STOCKYARD ROAD USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE 3 □XWidowed 4 □ Divorced ARMY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER HOSPITAL 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be innent of Health and Mental I shout: If Item 27 is merked o SAMUEL LEE JONES ETHEL WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL RASSMUSSEN - DAUGHTER 3989 STOCKYARD ROAD, EDEN, MARYLAND 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any injury or ot
once: 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM.GDNS. 01-22-2005 HEBRON, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 10 Culley 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A SCVD **Physician** /Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 No Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 2□ No 1 ☐ Yes 2 PNo 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral E 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 1/20/2005 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 2180x 106 Milford ST. 7 504B Dar.M.D. Babulal 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				epartment of Health and Me		ene				
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Rag 2. Date of Death	1. No. 2005 03352				
	Physici	an	Daniel Webster Johnson, Jr.		Month	Day Year				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	24, 2005 4:45 A M				
	LXAIIIII	ei	Homewood Retirement Center	Williamsport		Washington				
	Funeral		5, Social Security Number 6. Sex 7. Age (In yrs. last birt		8. Date of Birth (Month, Day, Y					
	Director		210-22-9133	rs. Months Days Hours Min.	Sept.23,	1927 Maryland				
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits				
	Maryl f sho	ō		amsport		1 □Yes 2 X No				
	28a	rect	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Country?				
	h with	Funeral Director	16505 Virginia Ave. Apt.A204	21795		USA				
	ems (ner	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	city Yes or No-	14. Race - American Indian,				
36	or it		1 Never Married 2 Married 1 Y Yes 2 No 1945—	1 ☐ Yes 2X No Specify:	iican, etc.)	Black, White, etc.				
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Exeminer must be notified at	d by	Year of Dates: 1946	· · · · · · · · · · · · · · · · · · ·		Specify: White				
5	n 72 n "nat	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workin; life, DO NOT use retired)	g 16	6b. Kind of Business/Industry				
712	withi iene. r ther	E O	Elementary/Secondary (0-12) College (1-4or 5+)	acher	-	ducation				
	filed Hygid other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name						
lar	and be Mental rked o	To B	Daniel Webster Johnson, Sr.	Mary Agne	s Mounta	in				
Maryland	2 should and Men is marke eumatic			Mailing Address (Street and Number or Rural	Route Number, C	City or Town, State, Zip Code)				
	1 and Health sem 27					ters,WV 25419				
Baltimore,	Pages 1 nent of H int: If ites iry or oth	-	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of cemeter)	Disposition (Name of Da Crematory or other place)	ate 20	20c. Location - City or Town, State				
┋	tmen tant:		`4 □Donation 5 □Other (Specify) Smiths	burg Crematory 01-25-						
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Livensee	rne Fune	ral Home,P.A.					
			425 S.Conococheague St. Williamsport, MD 217							
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or hear failure. List only one cause on each line.	of enter the mode of dying, such as caldiac of		Injerval Between Onset and Death				
	Physician / /Medical		disease or condition resulting in death) Due to (or as a consequence or	40 CANDIAL NEO	1 CTTU	n Minute				
	Examiner		/ Carro	ATTHE DISCORDE		Dr. Von				
	×	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1101007 11009		(U / 4h)				
	cuted nd ransit	Examiner	that initiated events							
oʻ	ate be executed hysician and he burial-transit	Ë	resulting in death) Last Due to (or as a consequence of	():						
8760,	hysic the bu	llcal	d							
x 68	Attending Physicien: The law requires that the death certifica r death. r death. sctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:		7.00					
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year				
P.O.	the d	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)						
	that	y P	Part II other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?				
rds	quire n sign uld be	d be	HTALA TIBALLATION (HAU	VICE	1 ☐ Yes	2 No 3 Probably 4 □Unknown				
Vital Records,	sw requires s been si s should I	Completed	VANKING WICON (ONO	VANY ANTES	24a, Was an	24b. Were autopsy findings available				
æ	The la	ШО	NUAR!		autopsy					
ţa	ien: rtifica ctor, p	Bec	25. Was case referred to medical	26. Place of Death (1 ☐ Yes 2 ☐ Check only one)	No 1 □ Yes 2 □ No				
	hysic his ce I direc	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing Home	e 5 🗆 Residenc	e 6 Other (Specify)				
Division of	ing P		27. Manner of Death 1 Anatural 5 Pending (Month, Day Year) 1 In	me of 28c. Injury at 28 ury Work?	ld. Describe how	injury occurred				
sio	tendi leath. tor: A the fu	cat	2 Accident investigation	M 1 ☐ Yes 2 ☐ No						
\leq	l or At after o Direct I in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, fare building, etc. (Specify)	n, street, factory, office	f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)				
	Hospitel or Attens 24 hours after deatl Funerel Director: tely filled in by the		29a. Certifier TC Certifying Physician: To the best of my knowledge	dooth	4					
	e Hospite 24 hours e Funerel etely filled	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	or investigation, in my opinion, death occurred	at the time, date	e and place, and due to the cause(s)				
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	29cLicense number	29d.	Date signed (Month, Day, Year)				
			1/200) //AGD ((A)) //AGT	Ta () (700)		JAV24,7001.				
			30. Name and address of person into completed cause of death (tem 23a), []	vpe, Print)	11.					
		- 1	(TO) 1/2/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	11/ 1/1/2000 1/1/20	+1112	16-2011 116-1				
91	19+1) (extra e (me (even, um)	19) MINTERNITUE	- ITTO	GITTAUN, WOO				
51	19+1 Sta Registra		31. Date filed (Month, Day, Year) 6 2005 32. Registrar's Signature	19) HUN (HEEN FUE	- (ITC)	STOR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) **Physician** James Klaverweiden, Sr. Edwin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisburg If Under 1 Year | If Under 24 Hrs. gional Medical Center DIDSULA Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days 67 Yrs. Director 214-32-6386 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b County 5 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene. Item 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic event, The Wadical Examinar must be mailitied at **Funeral Director** WEIDEN Delaware Sussex Delmar 10e. Street and Number 10f. Zip Code 12175 Line Road 19940 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Arm Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Army 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and 2121 Elementary/Secondary (0-12) College (1-4or 5+) 9 Truck Driver 17. Father's Name (First, Middle, Last) Be James T. Klaverweiden 2

19a. Informant's Name/Relationship (Type, Print)

21. Signature of Funeral Service Licenses

Month Year 2310 M TANUADY 2005 4c. County of Death WILDMICO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

October 26, 1937 Maryland

10g. Citizen of What Country? USA 14. Race - American Indian,

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Black, White, etc. Specify: White 16b. Kind of Business/Industry

Trucking 18. Mother's Name (First, Middle, Maiden Surname)

2. Date of Death

Elsie Ellen Johnson

Hours

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mary Frances Budd Klaverweiden (wife) 12175 Line Road, Delaur, Delaware 20b. Place of Disposition (Name of Date 20c. Location - City or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 🖔 Other (Specify) Entartment Old Mardela Cemetery January 22, 2005 Mardela Springs, Maryland

22. Name and Address of Facility Holloway Funeral Home Professional Association

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a shock, or heart failure. List only one cause on each line. Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Baltimore.

Box 68760.

P.O.

Vital Records.

Pages 1 ment of F Department of Importent: If it any injury or o once.

Physician

Hospitel or Attending Physicien: The law requires that the death certificate be executed

/Medical Examiner

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after death Diractor:

To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b

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Examiner

Physiclan/Medical

Be Completed by

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Certification:

Medical

1 Natural

2 Accident

Hlon Davis

3 Suicide

Ames

Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Aspiration freur	nonia		
Due to (or as a consequence of):			
Adult Respirations	Distrose	Syndro	me
Pue to (or as a con equence of):		7	
Wente myocard	ial infa	rction	
Due to (or as a consequence of):		,	
Change Obet	1: 01		Dance

UMMONERY IF FEMALE

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 TYes 2 No 3 Probably 4 Unknown 24a. Was an

autopsy performed 2 No 1 ☐ Yes 26. Place of Death Check on one

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Year

25. Was case referred to medical examiner 1 ☐ Yes 2 ☐ No 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. May er of Death

2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred

min

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check on Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one

29b. Signalure and title of certifier my

mn

4

5 Pending

investigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Power 100 egistrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Doris Mae Keplinger /Medical 4b. City, Town, or Location of Death 24 2005 4c. County of Death 12:15 AM 4a Facility Name (If not institution, give street and number) Examiner Julia Manor Nursing Home Washington County Hagerstown If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 M 2 XF 80 Yrs Director 217-12-1209 Aug 30, 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Haatth and Mental Hygiena.
Int: If them 27 is marked other than "natural", or thems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ith and Mental Hygiena. ?? is marked other than "natural", or iteme 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 Yes X No Directo Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13108 Little Hayden Circle United States 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Truck Mfg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas Ogden Bertha C. Tewalt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Haalth a important: if Item 27 is any injury or other trate once. Ralph J. Deplinger (Husband) 13108 Little Hayden Circle Hagerstown MD. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery Jan 26 05 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 anu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumon, a Examiner Due to (or as a consequence of): Dementia Physician/Medical Examiner Mers 7hxi or Attending Physician: The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): iis certificate has been signed by the a diractor, paga 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Denknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After fillad in by the funer 1 Natural 5 Pending investigation М 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060396 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 JA R SHE 1) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			1 - For State Registrar	State of Marylar		artment of H			ene 2005	03355
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		ROBERT W	OODROW K	ELLEY			JANUARY	Day Year 22 2005	7 10 a M
	/Medic Examir		4a. Facility Name (If not institution, give s		L [] [] T	4b. City, Town, or	Location of Deat		4c. County of Deal	7.10 a M
	LXCIIII	iei	Frederick Memo		tal	Freder			Frederi	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs	8. Date of Birth		
	Director		214-30-1101	M 2□F 70	Yrs.	Months Days	Hours Min.	(Month, Day, Y		thplace (State or Foreign
	ס		Usual Residence of Decedent					Oct. 4,1	954	Virginia
	ylan		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Ma Ma	Director	Maryland Washin	aton		Hagerstov	vn			1 ☐ Yes 2 No
	r 28	irec	10e. Street and Number	9.0		10f. Zip Code		100	. Citizen of What Co	ountry?
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	4 within 72 hours after death with the Maryland liene. r then "naturel", or Hems 23a or 28a-f show the Medical Examinar must be motified at	Funeral		12. Was Decedent Ever in L	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	
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21215-0036	atura cal	Completed	15. Decedent's Educ		16a. Deced	fent's Usual Occupa	ation	16	ib. Kind of Business/	White Industry
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e,	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disposition			sition (Name of natory or other place			c. Location - City or	
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뜵			 4 □ Donation 5 □ Other (Specify) 21. Signature of Fueral Service License 	/ Ce				26,2005 Ha	gerstown,	Maryland
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	70 % a 0		(ung/l	XIV				ue St. Wil		,Maryland
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Вох	death certifica attending ph d for use as t	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn					23d. Date of deli	ivery
m	d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pregnancy Other (specify)			Month	Day Year
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	ding f	on	27. Manny of Death 1 ■ atural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
sio	Attending ir death. ector: After by the fune	cat	2 Accident investigation			M 1 🗆 Y	′es 2□No			
Division	r Ati	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Se							,	
	Hospital 24 hours a Funerel I	edical	29a. Certifier 1 Certifying Phys	ician: To the best of my knower: On the basis of examina	owledge, death	occurred at the tim	e, date and place	, and due to the caus	se(s) and manner as	stated.
	the hin 24 the Figure 1		one)	and manner stated.	THOU WHO OF THE	estigation, in my op	illion, death occu	ned at the time, date	and place, and due	to the cause(s)
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			1 this It to	in h	0	000	4767	9 1	124/05	
			30. Name and address of person who con	mpleted cause of death (Iter	n 23a) (Type,	Print)			-	
54	-4		Francis G. Grillo M		ver (i	+ \$103	Frede	rick M	D 2170	3
	Sta	te	31. Date filed (Month, Day, Year) 5 20	32. Registrar's Signa	ature	1	, 1. 9.5-(6)	,		
	Registr	ar	JAN 20 20	100 Access	De poly	rede				

Xandria Elaine Lecky Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00460 **RPD** State of Maryland / Department of Health and Mental Hygiene 1- State Certificate of Death Registrar AMEND ITEM #5 PER FH C845 7/28/05 JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Las **Physician** January 19, 2005 XANDRIA 0825 P ELAINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3400 Dean Drive Hvattsville Prince George's If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 9, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F 32 Yrs. Director Jamaica Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. other than "natural; or Items 23a or 28a-1 show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural; or items 23a or 28a-f shov treumatic event, the Medicul Exama, an must be notified at 1 X Yes 2 No Director Prince George's Maryland Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3400 Dean Drive Apt. 301 20782 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant 4 Private Pages 1 and 2 should be filed vent of Health and Mental Hygies ont: if Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alric George Lecky Carmelita Banton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Harlequin Ct. Upper Marlboro, Md 20774 Valrie A. Lecky/stepmother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Importent: if Ite any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 1/28/05 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funeral Service Licenses An Oldine 4001 Benning Road, NE Washington, DC Cluton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death wound Gunsho Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Records, P.O. the the 9 Unknown 9 Minknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: $_{4 \square \, \text{Nursing Home}}$ 5 $\square \, \text{Residence}$ 6 $X \otimes \text{Other} \, (\textit{Specify})$ At Scene P 1XXYes 2 □ No 3□ DOA 28a. Date of Injury (Month, Day Year) 1-19-05 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. | Director: After After Deceased Sho 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 3400 Decm Driw 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide corantment 10+ c To the Hospitel c within 24 hours at To the Funerel D Parking , MI 2075 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2005 24

(

29b. Signature and

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106

Registrar

State

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 20, 2005

			1 - For State Registrar	State of Ma	aryland / De	epartment of	Health and	•	iene 2005	03357
			Registrar 1. Decedent's Name (First, Middle	Lasti		Certificate of	Death	2. Date of Deat	eg. No.	
	Physicia	an	Wilbur	Larmo	00			Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,		1 –	4b. City. Town.	or Location of De		19, 2005 4c. County of Dea	9:00 pm M
	Examin	er		_		Finks			Carrol	
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthe	day) If Under 1 Yea	r If Under 24 H			thplace (State or Foreign
	Director		219-12-9035	1€M 2□F 7	9 Yr	s. Months Days	s Hours Mi	Dec 8	1925 Ma	ryland
	pu .		Usual Residence of Decedent 10a. State 10b. County	•	10c. City, Town o	or Location				10d. Inside City Limits
	fanyla ethor	5	Tod. State							1 ☐ Yes 2X No
	28a-1	Director	Maryland Carro	011	Fir	nksburg 10f. Zip Code			0g. Citizen of What Co	
	with Mary		_	- D4				'		outility :
	ms 2:	Funeral	1707 Lauterbach	12. Was Decedent	Ever in U.S.	21048 13. Was Decedent of If Yes, specify Cu		(Specify Yes or No-	USA 14. Race - Ame	erican Indian,
9	atter or ita	Fu	1 ☐ Never Married 2 ☐ Marri	Armed Forces? ed 1 ☐ Yes 2 ☐ N If Yes, Give	№ 1943			erto Rican, etc.)	Black, Whi	
21215-0036	within 72 hours atter death with the Maryland ene. Than "natural", or Ifams 23a or 28a-f ehow he Medical Evar it ar must be notified at	d by	3 Widowed 4 ☐ Divorced	Year or Dates:	1963	1 □ Yes 2 □ No	o Specify:		Specify:	White
<u>2</u>	natu	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(0	ecedent's Usual Occu	e during most of w	vorking	16b. Kind of Business	/Industry
12	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ife. DO NOT use retir	•			
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Maryland	d be antal	To Be	Wilbur Larmore					Malinowsk		
چ	should ind Men marka umatic	1	19a. Informant's Name/Relationsh		19b. N	Mailing Address (Stree			, City or Town, State, .	Zip Code)
	and 2 salth a n 27 is		Bob Larmore	Son	- 1	Jordan Mi		White Hal		
Baltimore,	- T 5 5		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pl	lace)	Date	20c. Location - City or	Town, State
Ĕ	Pages nent of I int: If its ury or o		1 ☑Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp			osary Ceme	1	21/2005	Dundalk, M	arvland
alti	permit. Departn Imports any inju		21. Signature of Funeral Service I	icensee		22. Name and Add	ress of Facility Pr	ritts Fune	ral Home &	Chapel, PA
<u> </u>	82 5 8		John K 14	ald.		412 Washi	ington Ro	d. Westmin	ster. MD	21157
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause of each li	the death. Do no	t enter the mode of dy	ing, such as card	liac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acut	to My	ocardi	al III	tavetro	-	Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or as	a consequence of					
	LAdmine	<u>.</u>	Sequentially list conditions.	b. 173 (a consequence of					
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	1-100	1-1	Dahat	es Helli	7 77 cm.
_^	death certificate be executed e attending physician and of for use as the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	: OPICA	CYCHY (C	70000	es o recio	7/.8
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89	ifficate g phy as the	ed		U						
Вох	leath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	2 DEstanta program	101		23d. Date of de	livery
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at		3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	Day Year
P.0	that the de led by the a detached t	Phy	9 🗆 Unknown							
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o	Phys r this aral di	: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da		atient 3 DOA	4 Nursing		ence 6 Other (Spe	ocify)
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Ö	s afte	Cert	4 E Nomicide	building, et	с. (Зреспу)			City or Town	n, State)	
	To the Hospital or Attanding F within 24 hours after death. To the Funaral Director: After completely tilted in by the funer.	edical (29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best Examiner: On the basis o	f examination and/	death occurred at the	time, date and pla	ice, and due to the co	ause(s) and manner as	s stated,
	thin 2 that that mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		nse number		9d. Date signed (Mont	
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	MIL		30. Name and address of person	who completed cause	ath (Itom 22a) (T		UUTL	.10	16100	, 2000
	.5		Dean H. Grif		Ridge Ro		nster, M	ID 21157		
	Sta	ite	31. Date filed (Month, Day, Year)	ART	ar's Signature	72.1				
	Registi	rar	JAN 2	1 2005	ever &	Coules				

State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month MARY ELIZABETH LEPPO 18, 2005 JAN. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER CARROLL HOSPITAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2/16/1920 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 T F 84 214-14-5412 Director Yrs MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28e-f show Examiner nast be natified at 1 ☐ Yes 2X No Director MD. CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2078 BETHEL RD. 21048 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) ASSEMBLY LINE MANUFACTURING 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES HOCK JENNY BELL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 i RICHARD W. LEPPO - SON 2078 BETHEL RD., FINKSBURG, MD. 21048 20b. Place of Disposition (Name of crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State | Memorial 2 | Cremation 3 | Removal from State EVERGREEN MEM. GARDENS 1/21/05 FINKSBURG, MD. permit Pages Department of Important: If it any injury or o * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, whear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a YULMONARY EMBOLI disease or condition resulting in death) DWEERS /Medical Due to (or as a consequence of): Examiner PRIMARY UNRNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 Ē No 9 Unknown 9 🗆 Unknown þ signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown ANENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' DIABETES 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 PNo After this certification funeral director, p To the Hospital or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Matural investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number W2+2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RETSTEPSION BUSINESS CENTER PRAKKEZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State of Ma	aryland ,	/ Depa		t of H	ealth a				21111	5 (3359)
			Decedent's Name (F	irst, Middle, Last,								2. Date of De				3. Time of Death	_
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σ.	law requires that the de as been signed by the a 2 should be detached t	/ Ph	Part II. Other significa	nt conditions cor	ntributing to death b	ut not resultin	g in the u	nderlying ca	use givei	n in Part I.		23e. Did t	obacco u	use contribute	lo the o	cause of death?	
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Division	- 9	Certification;	4 Homicide	determined	28e. Place of Inj building, et	c. (Specify)	, ramm, str	eet, ractory,	, OTICE		2	8f. Location (: City or To			Hurai H	oute Number,	
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 (Check only one)	Certifying Phys Medical Exami	sicien: To the best ner: On the basis o and manner sta	f examination	dge, death and/or inv	occurred a restigation,	at the time in my opi	, date and nion, deat	d place, a h occurre	nd due to the id at the time,	cause(s) date and	and manner d place, and c	as state due to the	e cause(s)	
	To the To the Comp	M	29b. Signature and title	of certifier	1			29c.	License	number			29d. Dat	e signed (Mo	onth, Daj	y, Year)	
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	W33		30. Name and address	0	Smpleted cause of d	eath (ttem 23	а) Туре.	Bigari	RON	CILT	Hell-	TST F	tes	R'THE	E	war	
			31. Date filed (Month,		40 N 4N	ar's Signature		/	LAX	10411	1566	-210	MA	uglas	(1)	21132	
	Sta Registr				2005 2005	ur a signature	H	1	0.					,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#20b-c, per Ett 68/042//th/05/ TT Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^{Year} **Physician** McDowe11 **Ulysses** 2100 January 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1(XM 2□F 498-32-5760 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Madical Examiner must be mailfuly at 1 Yes 2 ☐ No Bethesda Director Montgomery Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 United States 6545 Fallwind Lane Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No Specify: Specify: Black Ā 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) 12 years College (1-4or 5+) Government Residential Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Alta Mae Holden permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itan 27 is marked other any singing or other traumatic evant ADEs. Grady McDowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Flam Street Ft. Washington, MD 20744 Bernita Holden - Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State unk Date unk 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Leavenworth Nat'1 Ct. 2/1/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Leavenworth, KS 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licens Merra 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. After the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Toxic Megacolon /Medical Due to (or as a consequence of): Examiner Clostridium Difficele Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐No Coronary Artery Disease has page 2 rmeg? 2 No Cardiomyopathy 1 Yes Vital the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1√ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 of 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred وٰ Division or Attanding 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide filled Hospital within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number January 17, 2005 D42181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #3400N Enrique Daza, M.D. 106 Irving St., N.W. Wash., DC 31. Date filed (Month, Day, Year) 32. Reginar's Signature State FEB Q 4 2005 Registrar

CDOWC

			1 - For State Registrar		Marylar		artment of rtificate o		ınd Me	ental Hygi	ene g. No. Z	2005	0336
	Physici	an	Decedent's Name (First, Middle							Date of Death Month	Day	Year	3. Time of Death
	/Media	cal	David J. Mc 4a. Facility Name (If not institution		nhar)		Ab City Tour	n, or Location of		January		2005 ounty of Death	11:25 P
	Examir	ier	Salisbury Reha			_	Salis		Death			comi.co	1
ji.	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Ye	ar If Under 2		8. Date of Birth	1		nplace (State or Foreign untry)
	Director		222-24-6181	1 ☆ M 2□F	65	Yrs.	Months Da	ys Hours	Min.	(Month, Day, 10-31-19	39	Dela	aware
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					1	10d. Inside City Limits
	Maryi -f sho	Ď	Maryland Worce	ator		an Cit							1. Yes 2 No
	r 28a	Directo	10e. Street and Number	SCEI	000	an CIL	10f. Zip Cod	е		10	g. Citizer	n of What Cou	untry?
	th witi		703 St. Louis	Avenue			218	42			US		
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Decedent of	of Hispanic Orig	in? (Spec Puerto R	cify Yes or No-	14.	Race - Amer Black, White	
30	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	ied 1 ∐Yes If Yes, Give Year or Da	6		1 ☐ Yes 2 🔯 f				Sp		White
3	2 hour	ed b	15. Decedent	's Education	1165.	16a. Dece	dent's Usual Oc	cupation		11	Sb. Kind	of Business/li	
1215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or Itema 23a or 28a-f show other than "natural", or Itema 23a or 28a-f show event, Ita Medical Eve. It after the formal to a collised at	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	-4or 5+)	(Give	kind of work do DO NOT use ret	ne dunng most ired)	of working	g			
7	ed wii ygien ner th	Соп	12	2	,	Groun	ds Keep				Hote		
and	ntal H ed ott	Be	17. Father's Name (First, Middle, David J. McDad							(First, Middle, Ma V. Murra		mame)	
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2	D E M =		David Shane Mc							an City,	-		
ē,	ss 1 an of Heal item 2 r other		20a. Method of Disposition	6.535		Place of Dispo	sition (Name of matory or other p	olace)	Da	ite 20		ion - City or T	
Ĕ	Page ment ant: If ury o		1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		Ca	rey's (Cemetery	7	-20-0)5 F	rank	ford,	Delaware
gaitimore,	permit. Pages Department of H Important: If ite any Injury or ot		21. Signature of Funeral dervice t	_itensee						ices,Ltd		SW(est	
	402 40		23a Part 1 Enter the Voices or	complications that or	used the deat					ord, DE.		945	Approximate
	Physician /Medical Examiner		23a. Part1. Enter the 19 ase, or shock, or heart 1 ure. List Immediate Cause (Final disease or condition resulting in death)	_a. \ 4	or as a conseq	Co	20		ar dae or				Interval Between Onset and Death
	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a conseq								
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O. BOX	the death cer y the attendin ached for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2∏ Feta ant at time of d	Ideath 3	Ectopic pregnal Other (specify)				23d.	Date of deliv	rery Day Year
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	ding th. After fune	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Month	n, Day Year)	28b. Time of Injury	V	liuryat Vork? □Yes 2□N		d. Describe how	injury oc	currea	
DIVISION	al or Atten s after dea il Director d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At hog, etc. (Specif	ome, farm, str	eet, factory, offic			Bf. Location (Stre City or Town,		umber or Rus	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 certifying (Check only one) 2 Medical 6	g Physician: To the l Examiner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the	time, date and y opinion, death	place, and	d due to the cau	se(s) and and pla	d manner as s ce, and due to	stated. o the cause(s)
	To t Withi To tl	M	29b. Signature and title of certifier	m)				nse number		290	. Date si	gned (Month,	Day, Year)
			P ////	Town			0	2/5	4)		///	7/05	
H	1.		30. Name and address of person villiara H. Rob			, , , , .	Print) ve. Sal	ishuru	MD	21804			
	Sta	te	31. Date filed (Month, Day, Year)		gístrar's Signa		ve. sai	rendry	MID	21004			
	Registr	ar	JAN 2	U ZUUS 🦓	Muse	D. 16	DOMEL						

			for State Registrar	State of I	Marylan		artment of I				giene ()	05	03362
	Dhuaiai		1. Decedent's Name (First, Middle	, Last)				-		2. Date of Dea Month	th Day	Vaar	3. Time of Death
	Physici /Medio		V	VALTER	s.		MEYERS	SR		1	-	Year 005	1233P ^M
	Examin		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town,	or Location	of Death			y of Death	
			Peninsula Reg	gional Me	dical	Ctr	Salish	_			Wic	omic	:o
	Funeral		,	6. Sex 7. 1 M 2 ☐ F	Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign ntry)
	Director		219-26-8370 Usual Residence of Decedent	1 2 U 1	6	7 Yrs.				11-21	1-37		Md.
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	f sho	ō	Md. Worce	ester	P	erlin							1⊠Yes 2 □ No
	the the	Director	10e. Street and Number				10f. Zip Code				log. Citizen of	M/bas Carr	
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	r Itan	표	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	10.	Was Decedent of I If Yes, specify Cub	an, Mexica	n, Puerto	Rican, etc.)		ck, White,	
036	urs a	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 No	Specify:	:		Speci	^{fy:} Wh	ite
Ŏ	in 72 hours after death with the Maryland "naturel", or liams 23a or 28a-f show Laical Examiner must be notified at	ted	15. Decedent	s Education		16a. Dece	dent's Usual Occu	pation			16b. Kind of E		
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Maryland 21215-0036		ို	Henry Meyer						dith				
<u>Jar</u>	2 2 2 2		19a. Informant's Name/Relationsh				ng Address (Stree						Code)
	of Health item 27		Marcia Woodw	vard	act D		Upshur			-			
Baltimore,	S to I		20a. Method of Disposition 1 ☐ Burial 2 【Cremation	3 ☐Removal from Sta	ite 200. P	emetery, crei	sition (Name of matory or other pla	се)		Date	20c. Location	- City or To	own, State
Ħ	t. Partmentant		4 □Donation 5 □Other (Sp		Sa		ry Crem			9-05	Salis	bury	, Md.
Bal	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service L	OND.		22	2. Name and Addre	ess of Facili	ty				
			230 Boot Enter the diseases of	augu -		\ U	llrich	Fune	ral	Home F	Berlin	, Md	. 21811
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	only one cause on each	n line.	_		ng, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
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ш		<u>-</u>	Sequentially list conditions,	b. Due to (or	as a consequ	OCCA	L Die	3071C	car	17		-	Comment.
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89		Physician/Medical		u.						-			
Вох	law requires that the death certific as baen signed by the attending p 2 should be detached for usa as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			7				23d. Da	ate of delive	erv
	death e atte id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	at time of de]Ectopic pregnanc] Other <i>(specify)</i> _	у				onth	Day Year
P.0	at the de by the a stached	hys	9 🗆 Unknown	9□ Unknowr	1								
S, F	es tha gned be dei	by P	Part II. Other significant condition			ulting in the u	nderlying cause gr	ven in Part I		23e. Did toi	bacco use con	tribute to th	ne cause of death?
ğ	w require baen sig		0118756188	MRW17	us	144	(11			1 □ Ye	es 2 📉 No	3 Prob	abiy 4 Unknown
သူ	law re as ba	ompleted	CHRUSICO 1.	STEHBL ;	Taus 4	I.F.F.e.	CLEHCY			24a. Was a	n 24b.	Were auto	psy findings available
of Vital Record	9 4	mo.	PHEUM	OLIGHS	B	LATE	RAI			autops perform	ned?	death?	mpletion of cause of 2□ No
ita	icien: Th certificate ector, pag	BeC	25. Was case referred to medical					26. Place	of Death	Check only on		1 🗆 1 62	2 L NO
<u>_</u>	alis dii	10	examiner? 1 ☐ Yes 2 SNo	Hospital: 1 XInpa	atient 2	ER/Outpatier	t 3 DOA Ott			ne 5 Reside		ner (Specif	y)
		ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I	njury Da <i>y Year)</i>	28b. Time of	28c. Inju Wo	ry at		28d. Describe ho	w injury occur	red	
Sio	Attending it death. actor: After by the fune	catle	2 Accident investig	ation			M 1	Yes 2□	No				
Division	ol or Attend after death Diractor: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ned 286. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		- 2	28f. Location (St City or Town	reet and Numb n, State)	ber or Rura	l Route Number,
	urs af	ပိ	- /										
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical E	Physician: To the be xaminer: On the basis	s of examinal	wledge, deati	occurred at the ti	me, date an opinion, dea	d place, a	and due to the ca	ause(s) and ma	anner as si	ated. the cause(s)
	To the P within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens						
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			20 Name and addition	11. (Th	rcial	e W	1000	1075	140		1119		
L			30. Name and address of person v	RIUIZA S	or death (Item	23a) (Type,	Print) DR. F	TIZLIER	1 ll	11. (3A	COMO	Mil	>
	Sta	te	31. Date filed (Month, Day, Year)	32. Agi	strar's Signa	bury A	1 4.	-74	-10/2	July 1	NID	d/ E	7
	Registr		JAN & .	- 7002	ever.	D A	paren						

1. Decedent's Name (First, Middle, Last) Physician	Certificate of Death		g. No.	
Medical MARIAUNE J.	VIACK	2. Date of Death Month Jan •		3. Time of Death 1:55 PM
Examiner 4a. Fecility Name (If not institution, give street and number) Salisbury Nursing and Rehalt	4b. City, Town, or Location of Sali		4c. County of Death Wicomico	
Director 2/4-42-9606 1 M 27 F Usual Residence of Decedent	(In yrs. last birthday) If Under 1 Year If Under 24		9 Birthr	place (State or Foreign
The street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 11. Marital Status 12. Was Decedent Every Amned Forces?	If Yes, specify Cuban, Mexican, I	? (Specify Yes or No-	g. Citizen of What Cour U 5 14. Race - Americ Black, White, Specify: B	ean Indian,
To Dark Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 19 A Service Married 2 Married 19 A Service Married 19 A Service Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service Married 2 Married 19 A Service M	DELF EMPLO	YED YED	DAY CA	RE
O TO DESCO O FLEDEN / ACIDIDAT	19b. Mailing Address (Street and Number	7 0	JONES City or Town, State, Zip	REID Code)
1 □ Burial 2 Cremation 3 □ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)		SOON MD Do. Location - City or To	2 100 9 own, State
Question or	22. Name and Address of Fallity 917W, TSABEL	BENNIE A ST. SA	SMITH CISBURY, 1	F/H MD. 21801
C serve Cate (Lade by Land and Lade by Lade b	consequence of):	rdiac or respiratory arres	a. (Approximate Interval Between Onset and Death
6876(inticate be unificate by uppricial as the burn ledical.	pregnancy □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive Month	ny Day Year
Part II. Other significant conditions contributing to death but if	not resulting in the underlying cause given in Part I.	23e. Did toba.	cco use contribute to th	e cause of death?
Vital Record sicien: The law requirements been sequence of the	OS Disco et	24a. Was an autopsy performe	≝No 1 LIYes	osy findings available inpletion of cause of
27. Manner of Death 28a. Date of Injury (Month, Day Y	2 ER/Outpatient 3 DOA Other: 4 Doursi	Death Check only one) ng Home 5 Residence 28d. Describe how	ce 6 ☐Other (Specify	')
5 2 6 0		City or Town, :	·	
29a. Certifier 1 Certifying Physician: To the best of received to the best of	my knowledge, death occurred at the time, date and p kamination and/or investigation, in my opinion, death d. 29c. License number	occurred at the time, date	se(s) and manner as sta e and place, and due to I. Date signed (Month, L	the cause(s)
30. Name and address of person who completed cause of deal	DZ879	9	1/19/05	-
WILLIAM ROBINS, M.D. 200 State 31. Date filed (Month, Day, Year) 32. Refetrar's	CIVIC AVE., SALISBURY, MI	21804		

215 Mobray William

			State of Manuaged / Donor		•	9	
			State of Maryland / Depar	rificate of Death		20115	03364
			1. Decedent's Name (First, Middle, Last)	ilicate of Death	Reg. 2. Date of Death	No.	
	Physicia	an	WILLIAM WALTER MOBRAY, JR.		Month	Day Year	3. Time of Death
	/Medic			4h City Town and ageting of Death	01 /	8 2005	0015 M
	Examin	er		4b. City, Town, or Location of Death		4c. County of Death	
_	Funeral		Kenin Sula fegional Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WILDM	iCO place (State or Foreign
	Funeral Director			Months Days Hours Min.	(Month, Day, Ye 04-14-194	ar) Cou	IDENCE, RI.
			Usual Residence of Decedent		04-14-194	O TROV	IDENCE, KI.
	how		10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	e Ma	cto	MD WICOMICO SALISBU	RY			1 ☐ Yes 2√ No
	or 26	Oire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	be filed within 72 hours after death with the Maryland d al Hygiene. d other than "natural" or Itams 23a or 28a-f show event, the Madical Examiner must be multiwat at	Funeral Director	803 OUTTEN ROAD	21804		US	A
	er de	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W.	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
၁	s aft	by F	1 ☐ Never Married 2 ፟ Married 1 ☐ Yes 2 Ñ No If Yes, Give 1 ☐ S Give 1 ☐ Year or Dates:	☐ Yes 21 No Specify:			HITE
3	hour ture			nt's Usual Occupation	105		
2	in 72	olet	(Specify only highest grade completed) (Give ki	ind of work done during most of workir O NOT use retired)	ng lbb	. Kind of Business/Ir	idustry
7	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CCOUNTANT		SELF EMPL	OVED
2	e filed withir Il Hygiene. other then vent, the M	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		OILD
Ö	should be filed with nd Mental Hygiene. marked other than matic event, Ite h	To B	WILLIAM WALTER MOBRAY, SR.	EVA JAMES	S		
<u> </u>	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	Route Number, Cit	ty or Town, State, Zij	Code)
Ě	27 tr			UTTEN ROAD, SALISB			
ה ה	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe		20a. Method of Disposition 20b. Place of Disposit			. Location - City or T	own, State
=	Pages nent of int: If It iry or o		A burial 2 Cremation 3 Hemoval from State	L MEM. GDNS. 01-2	1_2005 #F	DDON - MAD	SZT ANTIN
	permit. Pag Department Important: I any Injury o once.	Ì	21. Signature of Juneral Service Licensee 22.	Name and Address of Facility BOUT	T-2002 UE	AI HOME	TNC
ă	Departiment of the policy of t		Milleso for Mung 70	O5 EAST MAIN STREE	ET.SALISE	HE HOME,	INC.
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac or	respiratory arrest,	OKI JIMKI II	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	COACTC			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	Sepsis			1
	Examiner			Prumonia			7
	or depth of	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	11.00(1.10.11.00			
	cuted ad ransi	Examiner	that initiated events				
oo,	te be executed ysicien and e burial-transit		resulting in death) Last Due to (or as a consequence of):			70.0	
-	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	ca	d				
00	artific ing p	Physician/Med	IF FEMALE:				
ò	ath ce ttend or us	lan/	23b. Was decedent pregnant 23c. It yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliv	,
5	the a	/slc	1 Yes 2 No 4 Pregnant at time of death 5 (Other (specify)		Month	Day Year
Ē	d by fetac		Part II. Other significant conditions contributing to death but not resulting in the und	lank from the second se	on- Dida-		
ń	signe signe	þ		eriying cause given in Part I.		o use contribute to t	ne cause of death?
, S S	requ	etec	Right Luy mass		1 Tes	2 No 3 100	Sabiy 4 Unknown
ה כ	siclen: The law s certilicate has b lirector, page 2 si	Completed	Liver mass		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
=	ysiclen: The is certificate hi director, page	Ö			performed		2 🗆 No
N I G	iclen	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	(Check only one)		
5	Phys this al dir	J.	To 2 Envoutpatient			6 ☐Other (Specif	y)
=	• Attending Ph er death. • ector: After th by the funeral	o	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how in	njury occurred	
2	ttenc death stor:	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	01.1		
2	or A after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	it, factory, office	City or Town, St	and Number or Rura ate)	al Houte Number,
_	spital ours ieral filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death of	accurate at the time data and place a	and due to the serve	(a) and	
	24 hos 24 hos efely	edical	(Check only one) 2 Medicel Siminer: On the basis of examination and/or invegrand manner stated.	stigation, in my opinion, death occurre	d at the time, date	and place, and due to	tated. the cause(s)
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	->-0		· Chem	HT049)		1/19/05	
	an		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr			11.11.	
	500		Christopher Souder IM F. Co.	mil St Sal-	hiril N	10 218	701
	Sta	te	31. Date filed (Month, Day, Year) 32. Bigistrar's Signature	vii II. · Mujoj	219/11	0/10	01
	Registra	_	31. Date filed (Month, Day, Year) JAN 2 0 2005 32. Registrar's Signature	relie			

			1 - For State Registrar	State of M		/ Depa		t of H	ealth a	and M			005	033	65
	Physici	ian	Decedent's Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Last, Decedent Name (First, Middle, Middle, Last, Decedent Name (First, Middle, M								2. Date of Dea Month	Day	Year	3. Time of De	
	/Medi	cal	Ruben H. Marshall 4a. Facility Name (If not institution, give		-1		4b. City, 1	Four or	Logation	of Death	Jan	17	2005 nty of Death	0230	M
	Examir	ner	Snow Hill Nursing			er	Snow			JI Death			rceste	r	
	Funeral		5. Social Security Number 6. Sec	7. A	ge (In yrs. la:	st birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h		ace (State or F try)	oreign
	Director		219–07–3786 10 Usual Residence of Decedent	M 2□F	89	Yrs.	Wichting	Days	riours	iviai.	Mar 5,		Court	MD	
	ow or		10a. State 10b. County		10c. City,	Town or Lo	cation			~-			11	Od. Inside City I	Limits
	Many e-f sh iffed	tor	MD Worceste	er	Snc	w Hi]	.1							1 XYes 2	□ No
	or 28	Oire	10e. Street and Number				10f. Zip					10g. Citizen	of What Coun	try?	
	s 23e	Funeral Director	501 Maple St.	10.111	-	1		2186					U.S.		
	ter de Item	-une	11. Marital Status 1 Never Married 2 Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ∑	?	. 13.	Was Decede If Yes, speci	ent of His ify Cubar	panic Ori , Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White, (
99	urs af	ρ	3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	• X □	Specify:			Spe	cify: Blac	ck	
2-0	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)		16a. Dece	dent's Usual	l Occupa	tion urina mos	t of worki	ina	16b. Kind of	f Business/Inc	ustry	
121	within ene. then	ldm	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work					-	,		
d 2	filed Hygie other ent, II	a	17. Father's Name (First, Middle, Last)				Truck			or's Name	(First, Middle,		umber		
<u>a</u>	Mental Merked o	To B	James Marshall						Nanc	v Foi	reman				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 Is marked other then "neturel", or items 23e or 28e-f show tiem 27 Is marked other then "neturel", or items 20e or 28e-f show other treumatic event, I'm Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address			<u> </u>	l Route Numbe	r, City or Tov	vn, State, Zip	Code)	
	1 and 3 Health sem 27 other tr		Cathy Robins/grand	ldaughter			Swiss								
Baltimore,	Pages 1 ar	'	20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ F	emoval from Stat	9		sition (Nam natory or oti				Date	20c. Locatio	on - City or To	wn, State	
Iţir			'4 □ Donation 5 □ Other (Specify) 21. Signature 1 Fig. (1) 5 bytics Lights	20	Shil		C Ceme		-		/2005	Pocom	oke, M)	
Ba	permit. Departr Importe any inju		23a. Part1. Enter the disease, or complete or head failure. List control								neral Ho	ome			
8760,	Physician / Medical Examiner	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Oue to (or a	s a conseque s a conseque s a conseque	nee off:	716	Sylv			<i>> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \</i>			2 eg	
.O. Box 6	I the death certific by the attending pl ached for use as t	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	eath 3]Ectopic pre] Other (spe						Date of deliver Month	y Day Yea	r
rds, P	w requires that been signed is should be det	by	Part II. Other significant conditions core	stributing to death	but not result	ing in the u	nderlying ca	use giver	n in Part I.	٠.	23e. Did to			e cause of deat	
Vital Records,	sicien: The taw requ certificate has been rector, page 2 shoule	Completed	Hypothy	roile	m						24a. Was a autop perfor 1 Yes	sy	prior to com death?	sy findings ava pletion of caus	
Vit	sicien: Th certificate irector, pag	Be	25. Was case exerted to medical examiner? 1 Yes 2 No	ospital:		2/0		Other			(Check only or				
of	y Phys er this eral di	7; To	27. Manner of Death	1 ☐ Inpat 28a. Date of In (Month, D		NOutpatien 8b. Time of		lc. Injury : Work?	4 NU		ne 5 Resid 28d. Describe h				
ion	ttending f death. stor: After / the funer	atlo	1 ★Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, D	ay Year)	Injury	М		? es 2□1	No					
Division	tel or Atters a strenge of Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inbuilding, 6	njury - At hom etc. <i>(Specify)</i>	e, farm, str	eet, factory,	office		2	28f. Location (S City or Tow	treet and Nui n, State)	mber or Rural	Route Number	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physic (Check only one)	sician: To the bes ner: On the basis and manner s	of examinatio	edge, death n and/or inv	estigation, i	in my opi	nion, deat	d place, a	and due to the co	ause(s) and late and place	manner as sta e, and due to	ited. the cause(s)	
	To To To To	Σ	29b. Signature and title of certifier	7 1	00	7.	29c.	License	number			-	ned (Month, D		
,	108		sregorio la	1/200	Ko,	-> M	VV	1	75	OS	1	0/-1	18 -	05	
	-00	4	AND Name and address of person who co					411	APEG	000	DRIVE	Citie	ZMOV	MD 210	7~!
	Sta	ate	GREGORIO M. B 31. Date filed (Month Pay Year) 5 20	32. F gis	trar's Signatur	9	120	ינדור/י	nd ck	\ <u>\</u> \	DICIVE	7417	PULY,	MIN ZIB	<u>, U </u>
L	Regist		JAN Z D 20	U5 Ske	wa l	7. B	me	•							

				partment of Health and Mertificate of Death		iene g. No. 20 (05 03366
	Physicia		1. Decedent's Name (First, Middle, Last) Mary Catherine MARKER		2. Date of Deat Month	h Day	3. Time of Death 76ar 8:35 a. M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of	
			Homewood at Williamsport	Williamsport		Was	shington
	Funeral Director		5. Social Security Number 213-18-9024 6. Sex 1 M 2 TF 7. Age (In yrs. last birthday 1 Yrs.		8. Date of Birth (Month, Day, Sept.16	,1923	9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary Indi	tor	Maryland Washington	Hagerstown			1 ☐ Yes 2Ã No
	in the	irec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of Wh	at Country?
	23a c	raiD	11325 Dogwood Drive	21740		USA	
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel", or items 23a or 28a-f show do other than "naturel", or items 23a or 28a-f show event, it e Modical Examinar must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 SWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ZNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2☑No Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
- 2	72 hou	Completed	15. Oecedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of worki		16b. Kind of Busi	ness/Industry
21	ithin 7.	mple	Elementary/Secondary (0-12) Coflege (1-4or 5+)	DO NOT use retired)	ng		
22	filed w Hygier other ti ent, to		11 0	homemaker 18. Mother's Name	/First Middle I	her own	
Maryland 21215-0036	ages 1 and 2 should be filed v nt of Health and Mental Hygie t: If item 27 is marked other t f or other treumetic event, IL	To Be	Bruce E. Martin	Nora	May Bor	ne	
Maj	D 77 C 0			ling Address (Street and Number or Rura 325 Dogwood Dr., Ha			
ē,	s 1 and Heal		20a. Method of Disposition 20b. Place of Disposition				ity or Town, State
Ĕ	Pages nent of I ant: If it ury or o		LES Burial 2 Cremation 3 Chemoval from State		6/05 H	lagersto	wn, Maryland
Baltimore,	permit. Pages 1 an Department of Heall Important: If item 2 any injury or other once.		XIID W	Name and Address of Facility 415 E. Wilson Blvd		H FUNERA	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. PNEUMOUTA				Onset and Death WCC 5
	/Medical Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ncuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (1993) of it is a sequence of the initial translated events c.				- 3
90,	ificate be executed 3 physician and is the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):				
58760	ficate I physi s the b	edicai	d			····	
X	leath certific attending p I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date	00.0
	at the dea by the att tached fo	Physician/Me		Other (specify)		Month	n Day Year
Records, P	ires tha signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob		ute to the cause of death?
O O	aw requ s been 2 should	Completed	Chroke.		24a. Was a		ere autopsy findings available
		Com			autops perform	ned? dea	or to completion of cause of ath? ☑Yes 2☐ No
Vital	sicien: Th certificate irector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death			
o	Phys this al dii	: To	1			nce 6 □Other	
O	ding th. : After s fune	tion	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	zod. Describe no	w injury occurred	
Division of	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director.	ertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town		or Rural Route Number,
	To the Hospite within 24 hours To the Funerel completely filled	Medical C	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, deal (Check only one) 16 Certifying Physician: To the best of my knowledge, deal (Check only one) 29a. Certifier (Check only one)	ath occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the ca	use(s) and mannate and place, and	er as stated. d due to the cause(s)
	To th within To the compli	Me	29b. Signature and title of certifier	29c. License number		The same of the sa	Month, Day, Year)
				D26506	5	Janua	7,2005
ار	1, 10		30. Name and add east of person who completed cause of death (Item 23a) (Type	Print)	- 1/2	2 ~	51745
2	H-10 Sta	te.	31. Date filed (Month, Day, Ygar) 32. Registrar's Signature	Mone Hog	ONON	n VIHS	4717
	Registr	9 .9	31. Date filed (Month, Day, Year) JAN 25 2005 32. Registrar's Signature	V			

Examiner

Funeral Director

	Pleas	se Type or	Print in	Black	Indel	ible Ink.	Ensi	re A	II Copies	s Ar	e Leg	ible.		
. For		State o	f Maryla	nd / D	epartn	nent of H	lealth	and N	tental Hy	/gie	ne			
1 - State Registrar				(Certific	cate of	Death	1		Reg.	No.	05	03	35
1. Decedent's Name (I	First, Middle	, Last)							2. Date of D		_		3. Time o	f Death
Dorothy El	lizabe	eth Mumma							Januar	_	Day	2005	9.20	ρМ
4a. Facility Name (If no	ot institution	, give street and nur	mber)		4b.	City, Town, o	r Location	of Death	TO UNIOUT	0	4c. Count			
Reeder's N	Memori	al Home			B	oonsbo	ro			1	Washi	ngto	n	
5. Social Security Num 214-09-425		6. Sex 1 □ M 2 □ XF	7. Age (In yrs		Mor	Inder 1 Year oths Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Jan. 14	ay, Ye	år) 1912	9. Birth Con	nplace (State untry)	
Usual Residence of De														
10a. State	0b. County		10c. C	City, Town	or Location	ר							10d. Inside C	
MD	Washi	.ngton		Hager	stow	n							1 Yes	2 □ No
10e. Street and Number	er				10	f. Zip Code				10g.	Citizen of	What Co	untry?	
11 W. Balt	timore	Street				21740					US			
11. Marital Status		12. Was Dece Armed Fo		U.S.	13. Was D	Decedent of H	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - Amer	rican Indian,	
1 Never Married 3 Widowed 4 [ed 1 ☐ Yes If Yes, Giv Year or D	2 XNo			es 2⊠No	Specify		, , , , , , ,		Specif		White	
(Specify	5. Decedent only highes	's Education t grade completed)	-	(0	Give kind o	Usual Occup	during mos	st of work	ing	16b	Kind of B	lusiness/l	ndustry	
Elementary/Seconds	ary (0-12)	College (1	-4or 5+)		life. DO No	OT use retired Knitt	,			C	lothi	ng M	anufac	ture
17. Father's Name (Fir	rst, Middle, L	Last)					18. Moth	er's Nam	e (First, Middle					
Harlan Win	nfield	l Smith					Barb	ara	Ellen 1	Lew:	is			
19a. Informant's Name Robert M.			n						al Route Numb Ceet, Ha					0
20a. Method of Dispos				Place of D	Disposition	(Name of or other place	e)	ı	Date	20c.	Location -	City or T	own, State	
	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 1/28/2005 Hagerstown, MD													
21. Signature of Fune	Service L	icensee /	>		22. Nan	ne and Addres	s of Facili	^{ty} Ger	ald N.	Mi	nnich	Fun	eral H	ome
1/13	-55	K	1						et Ha					

Physician /Medical Examiner

the attending physician

use as the

should be detached for

completely filled in by the funeral director, page 2

Medical Certification: To

this certificate

within 24 hours after death. To the Funeral Director: After

Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ahov any injury or other traumatic event, the Nexical Examinat must be notified at

death

Pages 1 and 2 should be

U

DOROTH

NAME: MUMMA,

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 140 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 □ Yes 2 □ No

5 Pending

Praveen Bolarum

5

31. Date filed (Month, Day, Year)

investigation

6 Could not be determined

27. Manner of Death

1 - Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one) 29b. Signature

Dr.

Immediate Cause (Final disease or condition resulting in death)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

1 Inpatient

28a. Date of Injury (Month, Day Yeer)

9 Unknown

ASCUD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Algheiners diverse

Dubto (or as a consequence of):

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)

28b. Time of

Injury

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

3 DOA

28c. Injury at Work?

Metasfalic breast cancer (R)side

23d. Date of delivery

Year

Approximate Interval Between Onset and Death

chosec.

242	Wasan	24h	Wore autonou fir	adio an available
	1 🗆 Yes	2 🗆 No	3 Probably	4 Othknown
23e	. Did tobac	co use cor	tribute to the cau	ise of death?

a. Was an autopsy performed?	24b. Were autopsy findings availabed prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩6
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26.	Place of Dea	ith (Cr	ieck only one)		
Other: 4	Nursing H	ome	5 Residence	6 ☐Other (Specify)	
Injury at Work?		28d.	Describe how inju	ury occurred	

fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occu Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
title of centifier	29c. License number	29d. Date signed (Month, Dey, Year)

1[

· MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340 Mills Street, Hagerstown, MD 21740 / 301-739-7100 32. Registrar's Signature

00062223

9H-4 State Registrar

DHMH 17 Rev 1/2001

marked

106. Street and Number 9701 - Veirs Dr., 106. Street and Number 9701 - Veirs Dr., 11. Marital Status 1 Never Married 2 Married 1 1 Yes, specific personal p	nt of Health and Mental Hygiene te of Death Reg. No. 2005 0336
Aa. Facility Name (If not institution, give street and number) National Lutheran Home 5. Social Security Number 218-18-4619 Usual Residence of Decedent 10a. State 10b. County Md. Montgomery 10c. City, Town or Location Rock 10b. Street and Number 9701- Veirs Dr., 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual (Give kind of world) 16b. Do Not us 17 Note of the property of the p	2. Date of Death Jan. 18, 2005 3. Time of Death 4:45 A
Director 218-18-4619 1 M 2 XF 81 Yrs. Months	4b. City, Town, or Location of Death 4c. County of Death
V pear 6 12 Regist	
V pear 6 12 Regist	tville 10d. Inside City Limits 1 Yes 2 □ No
V pear 6 12 Regist	20850 USA
V pear 6 12 Regist	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
# 5, 0 T ()	al Occupation ork done during most of working see retired) 16b. Kind of Business/Industry Nursing
To be a part of the part of th	18. Mother's Name (First, Middle, Maiden Sumarne) Fannie M. Peters
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Betty Bryan- Friend 24-Cre	s (Street and Number or Rural Route Number, City or Town, State, Zip Code) ee Dr.,Oxon Hill, Md. 20745
5 . 5 5 5	Crematory-1/19/05-Alexandria, Va.
65	nd Address of Facility 'Song Co., Inc. 110-16th Street, NW, Wash., DC
Physician /Medical Examiner 23a. Part 1. Enter the disease, or confidication: that caused the death. Do not enter the mode shock, or heart failure. List only one of use on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmi.	Onset end Death
Due to (or as e consequence of): Anemia Sequentially list conditions, if any, leading to immediate cause Enter Underlying	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
d	
d	ause given in Part I. 23b. Did tobecco use contribute to the ceuse of death 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow
The lew require. Set has been significant to page 2 should be completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the complete to the	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	1 ☐ Yes 2 💆 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)
examiner? Hospital: I Inpatient 2 ER/Outpatient 3 DO/	Other: 4 Nursing Home 5 Residence 6 Other (Specify)
25. Was case referred to medical examiner? Continue of Description	8c. Injury at Work? 1 Yes 2 No
A cocident specified by the state of the sta	City or Town, State)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier (2) Medical Examiner: On the basis of examination and/or investigation, and manner stated.	It the time, date and place, and due to the cause(s) end manner as steted.
29c.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	License number 29d. Date signed (Month, Day, Year) Jan.18,2005

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 4 2005

			1- State of M	laryland / Depa <i>Cei</i>	artment of H			ne No.2005	
	Physici /Medi	cal	Decedent's Name (First, Middle, Last) MARIAN LENORA MURRA Description Name (If not institution in the standard of the standard o		4.0		2. Date of Death Month January	Day Year 20,2005	3: Time of Death
ŀ	Examir	ner	4a. Facility Name (If not institution, give street and number, Bradford Oaks Nursing	Home	4b. City, Town, or CLinto	n		4c. County of Death Prince G	George
	Funeral Director		045-30-8044 ^{1□ M 2} √2 F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 8	ear) Cour	place (State or Foreign ntry) ash_DC
	saryland show	2	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				•	10d. Inside City Limits
	with the N t or 28a-f	Director	MD Prince George 10e. Street and Number	Forestv	101. Zip Code 20747			Citizen of What Cour	1 Yes 2 □ No ntry?
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural; or Items 23a or 28a-f show matic event, the Madical Examination was be mortified at	y Funeral	1928 Addison Road 11. Marital Status 1 Never Married 2 Married 17 Yes 2 Filt 1988 Give Report 1988 Give Re	? No	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No-	14. Race - Americ Black, White,	etc.
21215-0036	thin 72 hours e. an "natural", Medical Ex.	Completed by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	16a. Deced (Give	dent's Usual Occupa kind of work done o DO NOT use retired,	ition	king	Specify: Bla	dustry
	e filed wi Il Hygien other th	Be Con	17. Father's Name (First, Middle, Last)	Teac	her	18. Mother's Nam	e (First, Middle, Maid	Education	<u> </u>
Maryland	should be and Mental is marked o	ToB	William G. Montague 19a. Informant's Name/Relationship (Type, Print)	19h Mailir	n Address (Street a	Grace		ity or Town, State, Zip	Code
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		Danyelle M. Kensey/da	ught 9716	Natalie	e Dr. U	pper Mar	lboro,MD	20772
Baltimore,	Page ment o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)		natory or other place ill Cem	9)		Location - City or To	
Ball	permit, Departr Importa any inji		21. Signature of Funeral Service Licensee	//	Name and Address	Ce	dar Hill a Ave.Su	Funeral	Home, Ind
	Prrysician /Medical Examiner		23a. Part. Effer the disease, or complications that caused shock or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death) a.—Castri Due to (or as	d the death. Do not enterine. CCATCING a consequence of):				1	Approximate Interval Between Onset and Death
8/60,	cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
BOX 08		O I	IF FEMALE: 23c. If yes, outcome	of pregnancy				22d Date of delive	
	the death y the atten ached for u	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ny Day Year
cords, F	w requires that the death certif been signed by the attending should be detached for use a	by P	Part II. Other significant conditions contributing to death b	ut not resulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute to the	e cause of death? ably 4 [Unknown
Ž	The la ate has page 2	e Completed	25. Was case referred to medical				24a. Was an autopsy performed'	? prior to com	osy findings available inpletion of cause of
5	Phys this ral dii	ToB	axaminer? 1 ☐ Yes ★★o 27. Manner of Death 1 ★ Natural 5 ☐ Pending (Month, Da) 2 ☐ Accident investigation	ry 28b. Time of	3 □ DOA Other	4X Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify,)
	or A fter jirec in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injuding, etc.	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled it	edical	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or inve	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the cause ed at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
	To the To the Complex	×	29b. Signature and title of certifier	FN	29c. License D1854			Date signed (Month, Dan. 21, 20	
	15		30. Name and offess of person who completed cause of d Louis V. Kaufman, M.D.			entre,#	207 Wald	orf, MD	20602
	Sta Registra			ar's Signature					

			State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 205 0337	Π
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month 2/ 0 5 4b. City, Town, or Location of Death 4c. County of Death	M
	Funeral		Salisbury Center Genesis Elder Care Salisbury Wicomico S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)	-
	Director	J.	240-12-1005 27 27 27 27 27 27 27 2	nits
	death with the Maryland ims 23s or 28s-f show	by Funeral Director	MD Wicomico Hebron Yaras 2 100. Street and Number 101. Zip Code 109. Citizen of What Country? 107 Whayland Drive 21830 U.S.A.	
036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 le marked other than "netural", or items 23e or 28e-f show othar traumatic event, the Madical Exertiner must be notified at	by Funer	12. Was Decedent Ever in U.S. Armed Forces? 1	
21215-0036	d within 72 hours after giene. rrthan "natural", or Ite Itre Madical Evertine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16c. Bookkeeping 16b. Kind of Business/Industry	
Maryland	should be filed nd Mental Hygis marked other umatic event, II	To Be C	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grady Davis Hattie Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 le sny injury or othar trau ance.		Meredythe N. Carr - Daughter 107 Whayland Dr. Hebron MD 21830 108. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Dopation 5 □ Other (Specify) 21. Sign un of Funeral Servic License 108. Method of Disposition (Name of cemetery, crematory or other place) 109. Place of Disposition (Name of cemetery, crematory or other place) 109. Place of Disposition - City or Town, State 200. Location - City or Town, State 21. Sign un of Funeral Servic License 22. Name and Address of Facility	
	Physician /Medical Examiner	ilner	Holloway Funeral Home 501 Snow Hill Rd Sa1 MD 23a a 1. Enter the disease, or complications that caused a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sck, or heart failure. List only one cause or each ine. Approximate interval Between Onset and Death disease or condition resulting in death) Due to (if as a consequence of): Due to (of as a consequence of):	
Box 68760,	death certificate be executed ettending physician and of for use as the burial-transit	Physician/Medical Examiner	c. Due to (or as a consequence of): d. F FEMALE: 33b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Dive to (or as a consequence of): 4. 23d. Date of delivery 1 Dive to (or as a consequence of): 4. Appropriate to the past 12 months?	
P.O.	0 0	by Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Vital Records,	The law requi	Completed	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	le
n of	ng Phys (ter this uneral di	To B	5. Was case referred to medical examiner? 1	
DIS	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the to	0	4 Homicide determined 200. Face of mighty skillottle, fallin, street, factory, office 201. Location (Street and Number of Hural Houte Number, City or Town, State)	
	To the H within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 9b. Signature and title of examination 29c. License number 29d. Date signed (Month, Day, Year)	
	440		0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sill American Adhinas 200 (Luce AVE SALC: MI)	
	Sta Registra		1. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		rtificate of			ed. No. 3 O O F		
			Decedent's Name (First, Middle, Last))				2. Date of Deat	n 2005	8 Time of Death	
	Physicia		W	ILLIAM JO	SEPH NI	NER		JAN.	16, 2005	5:49 P M	
	/Medic Examin		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat		
		•	CARROLL HOSPITA	AL CENTER		WESTM	INSTER		CARROLI		
	Funeral		Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		hplace (State or Foreign untry)	
	Director		212-24-3587]M 2□F	80 Yrs.	WOTERS Days	Tiodis IVIIII.	4/24/	1924 MAR	YLAND	
	pu .		Usual Residence of Decedent 10a. State 10b. County	10	c. City. Town or Lo	ocation				10d. Inside City Limits	
	anyla shov	<u>_</u>	MD. CARRO		WESTMI					1 ☐ Yes 2 No	
	he M	ecto			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				0- 02:		
	with t	ă	10e. Street and Number 2625 SALEM BOTT	TOM DD		10f. Zip Code	157		0g. Citizen of What Co USA	untry?	
	9eth	Funeral Director		12. Was Decedent Eve	rin II S 13 1			acify Vas or No-	14. Race - Ame	ocan Indian	
	ter d	'n.	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No	10.0.	If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White		
336	urs af	ρλ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	7 II	1 ☐ Yes 2X No	Specify:		Specify: WH	ITE	
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. Ital Hygiene. In other than "natural", or items 23a or 28a-f show event, I're Madical Exerticer man be notified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business/	Industry	
215	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work		CONSTRUCT		
21	giene giene er tha	М	9 ()		CARPE	INTER &	FARMER	Z	AGRICULTU	RE	
nd	be filed vital Hygie doubler lessent, in	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)		
yla	Menta Menta arked atic ev	10		LIAM H. N	IINER		RHODA	BLOOM			
Maryland	2 shd and is m		19a. Informant's Name/Relationship (Ty								
	and ealth m 27 her tr		MARY E. NINER	- WIFE							
ore	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☑ Donayion 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo	natory or other pla	ce)	Oate C	20c. Location - City or		
Ë	Pa tmen tant: jury								SMALLWOOD	-	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signal of al S License	99					FUNERAL INSTER,	HOME MD. 21157	
			23a. Part1. Enter the disease, or complishock, or head failure. List only or	ications that caused the						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Cardi	ac. A	1(4th)	mia			Onset and Death	
	/Medical		resulting in death)	Due to (or as a co	onsequence of):	. 10.0		Λ			
	Examiner		Sequentially list conditions,	_ luna	can	cer a	ma advan	(ed			
	P =	ner	cause. Enter Underlying	Due to (or as a ex	equence of):	1.4	disea	0			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CONTL	arya	itely	01560	<u>\$</u>			
50,	oe ex	Ē		Due to (or as a co	insadna 🥕 oi).						
68760,	tificate be executed ig physician and as the burial-transit	edicai		d.							
	as as	-	IF FEMALE:	23c. If yes, outcome of p	organancy				604.5		
Вох	death cert e attendin ed for use	Physician/	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	very Day Year	
o.	D 0 D	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	9 01 084111 3 [
<u>α</u>	requires that the leen signed by th hould be detache		Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?	
ds,	uires sign	d by						1 🗀 Y€	es 2□No 3×Pr	obably 4 Unknown	
Record	> 10 0	Completed						24a. Was a	n 24h Were au	topsy findings available	
Re	The law ate has b page 2 st	ш						autops	y prior to o ned? death?	completion of cause of	
a	ician: Th	e C	25. Was case referred to medical				OC Disease of Death		No 1 ☐ Yes	2□ No	
of Vital		o Be	evaminer?	Hospital:	★ ER/Outpatier	nt 3 DOA Ott	26. Place of Death		ence 6 □Other (Spec	nife)	
		-	27. Manner of Death	28a. Date of Injury	28b. Time of				w injury occurred	my)	
On	th.: After	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	e <i>ar)</i> Injury		rk? Yes 2 □ No				
Division	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, str	reet, factory, office			reet and Number or Ru	ıral Route Number,	
Ö	Di di	Certification:	4 Nornicide	building, etc. (ьреспу)			City or Towr	, State)		
	> € E E E	edical	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of mer: On the basis of ex and manner stated	amination and/or in	h occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and Alle of certifier			29c. Licens	se number	2	9d. Date signed (Monti	n, Day, Year)	
•			> Maureer	1 (WH	W.	Do	43962		1/18/05	_	
	WILLA		30. Name and address of person who co	ompleted cause of death					1101	21157	
	4		101-0.	Mn, M.D.		Baltin	iore P	siva.	Westmins	te, MD	
	Sta		31. Date filed (Month, Day, Year) JAN 2 0 2	32. Registrar's	Signature	#				,	
	Registr	ar 🔝	UMIN & U Z	UUJ Market and a second	· · · · · · · ·	AD					

			State of Maryland / Depa	rtment of Health and Me tificate of Death		2005 00070
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
	Physicia		Edward James Plummer		January	Year 5:00 AM
	/Medic Examin	- 8	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	LXAIIIII	ą,		Williamsport	Wa	ashington County
	Funeral		10617 Harry Heth Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Ш	Director		213-40-4245 1XDM 2 F 61 Yrs.		ec 7 19	43 Maryland
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	f sho	ō	Maryland Washington William	cnort		1 □Yes X No
	28e-	Director	10e. Street and Number	10f. Zip Code	10g. Citi	zen of What Country?
	h with	i D	10617 Harry Heth Road	21795	IIn i	tod Ctator
	deat	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (Sper Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.
9	be filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "neturel", or items 23a or 28e-f show event, the Madical Examiner must be notified at		1 ☐ Never Married	☐ Yes 2X No Specify:		Specify: White
Ö	hours urel',	d by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Deced.	ent's Usual Occupation	16h Ki	nd of Business/Industry
21215-0036	n 72	Completed	(Specify only highest grade completed) (Give hilfe, D	kind of work done during most of working NOT use retired)	ig iso. Ki	nd of Basiliosa industry
7	with iene. than	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Co-Owner	Cor	nstruction Co.
ğ	il Hygi other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden	Sumame)
<u>a</u>	Mental Mental arked atic ev	To E	W. Louis Plummer	Frances	Louise 1	Metzgar
Maryland	2 shou and M Is mar eumati		19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or Rura	Route Number, City o	r Town, State, Zip Code)
	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		Jackie P. Sprow (Daughter) 7796 20a. Method of Disposition 20th. Place of Disposition	Lincoln Way Ea	st Fayet	tsville PA 17222
Baltimore,	e ° = 5		1X Burial 2 Cremation 3 Removal from State	latory or other place)		
Ë	t. Partmen tant: njury					gerstown Marylan
Ba	permit. Pag Department Important: any injury o			31 Eastern Blvd	glas A. 1 .N. Hager	Fiery Funeral Horstown MD 21742
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	0.1	Immediate Cause (Final disease or condition a End Stage C	Wernic Chost Pi	ummace	OLS Yearns
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	2 (2	\mathcal{O}	inconth c
	LAGITITIET	Ļ	Sequentially list conditions, if any, leading to immediate b. Due to jury us a consequence of the conditions of the cond	Jenny J	V	vico rucs
	ed sit	niner	r any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	111 9		Xpar C
_	xecul and	Examin	that initiated events resulting in death) Last c. Due to (or as a consequence of):			1000
8760	cate be executed obysician and the burial-transit	dicai E				
687	ificate g phys as the	edic				
Вох	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as i	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery
	death	sicia	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐	Other (specify)		Month Day Year
P.0	at the de I by the stached	Phys	9 Unknown	to the control of the	22a Did tabassa I	use contribute to the cause of death?
	res thai igned l	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	1 Yes 2	
ord	w require been sign	Completed	- Supragarior			
Records,	e law has b je 2 st	npie	<i></i>		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
H					1 Yes 2 2 No	
of Vital	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		C Cother (Consite)
o		- To	27. Manner Death 28a. Date of Injury 28b. Time of	28c. Injury at	ne 5 Pesidence 28d. Describe how injur	
on	ding I th. After funer	tion	1 12 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	l or Attendi after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
á	el or A s after il Direct	Certification:	4 ☐ Homicide building, etc. (Specify)		Only of Town, State	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(s) and at the time, date and	and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Mec	and title of partition	29c. License number		te signed (Month, Day, Year)
	F ≯ F 8	-	290. Signature and title of certainer	D45031	Ja	u 27 2005
•			30. Nam and address of person who completed cause of death (Item 23a) (Type,	Print)	- A 1	MD 21742
6	4-12		192114 C LATERSBURG	PK HAGER	STOWIU	111/42
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1		
9	Regist	rar	JAN 2 5 2005	saled		

			State of Maryland / Dep.	artment of Health and N		0000	00070
			Registrar 1. Decedent's Name (First, Middle, Last)	Tuncale of Dealit	2. Date of Death	I. No.: U U D	3, Time of Death
	Physicia		Dorothy Bell Peddicord		Month January	^{Day} 2005	173 OM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	<u> </u>	4c. County of Death	1
			827 Chestnut Street	Hagerst		Washi	
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 78 78 78 78	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day,)	(ear) 9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent		Jan. 7,1	.927 Mar	yland
	/land	İ	10a. State 10b. County 10c. City, Town or Le	ocation		1	0d. Inside City Limits
	Many a-f sh	tor	Maryland Washington F	lagerstown			Yes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show		827 Chestnut Street	21740		USA	
	tems	Funerai		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
50	be filed within 72 hours after death with the Marylar tal Hygiene. id other then "natural", or liems 23a or 28a-f show other then "natural", or liems roust burnelliked and event, the Marical Examinator cust burnelliked and	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺNo If Yes, Give 3 ☐ Widowed 4 ሺ\Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: W	nite
ş	2 hou		15. Decedent's Education 16a. Dece	dent's Usual Occupation	///	6b. Kind of Business/In	dustry
פ	e. Bn "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		-	
7	ad wit	Con	12 0 acco	ounting clerk		rane mfg.	
and	12 should be filed within "and Mental Hygiene." r is marked other then "reumetic event, It e Me.	Be	17. Father's Name (First, Middle, Last) Rush Hawbaker	18. Mother's Nam Mary	ie <i>(First, Middl</i> e, <i>M</i> a B rv an	aiden Sumame)	
Z	1 Men narke	70		ing Address (Street and Number or Ru		City or Tourn State Zin	Codol
<u>8</u>	d 2 sh th and 7 is n treum		1 1 2 1	⁷ Sherman Ave., Ha			
a)	ges 1 and 2 should tof Health and Men If item 27 is marke or other treumetic		20a Method of Disposition 20b. Place of Disp	osition (Name of		Oc. Location - City or To	
Saltimor	permit. Pages Department of h Importent: If ite any injury or of		1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State	nmatory or other place) 1 Cemetery 1/28	8/05 Ha	agerstown,	Marvland
	artme orten injur					JNERAL HOME	
ñ	Depar Depar Impor any ir		Scatt Minnight	415 E. Wilson Blvd			21740
r			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	-t: He- + D.	C = 1	4	Onset and Death
	/Medical		resulting in death) a	and	31.1-6	Dileio	
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. Change of the conditions of the conditio	uctuse Palz	morany	Diseis	
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(
	xecut and II-tran	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
20	sate be executed obysician and the burial-transit	caiE					
ρg	ificate g phy: as the	0	<u> </u>				
X Q Q	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of delive	·
	deat of for	Physician/Me	in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 4 \(\text{Pregnant at time of death} \) 5[Other (specify)		Month	Day Year
л О	at the 1 by th etach	Phys	9 🗆 Unknown		One Did take		a a course of docable?
	The law requires that the death certificate be executed to has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	230. Did 1002	acco use contribute to the co	pably 4 Unknown
0	w require been sign should t	eted			172316 T		
Vital Hecords,	elaw hast je 2 s	Completed			24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
<u>=</u>					1 ☐ Yes 21	INO 1 ☐ Yes	2 No
	sicier certil	o Be	25. Was case referred to medical examinar? 1 Pres 2 No Hospital: 1 Inpatient 2 FR/Outpatie		th (Check only one	oce 6 ⊡Other (Specif	(v)
o	Phys ar this aral dit	-	27. Manner of Death 28a. Date of Injury 28b. Time of Manner of Death	of 28c. Injury at	28d. Describe hov		y/
<u>0</u>	nding ath. r: Afte e fune	ation	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	r Atte er deg recto by th	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
<u></u>	ital or rs aft el Dir	Cer					<u> </u>
	Hospi 4 hou Funer Tely fill	icai	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only 2 ☑ Medical Examiner: On the basis of examination and/or in				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	and manner stated. 29b. Signatuse and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
	F 3 F 8		> Shuas lw. Ditto or MO	100-1062	J	an 25	2000
			30. Name and address of person who completed cause of death (Item 23a) (Type	/ ~	Lane -		
3	H-5		Dr. Edward W. Ditto.III. 19011 Orcha		agerstown	, Md. 21742	2
	Sta	ite	31. Date filed (Month, Day, Year) 5 2005 32. Projectrar's Signature	freiter			
	Regist	rar	ONIN NO LOUD AMERICA 10. F.	a service and a			

State

Registrar

31. Date filed (Month, Day, Year)

4 2005

				Please	State of Ma		/ Departr	nent of H	lealth and	-		-	
				Registrar			Certifi	cate of	Death		Reg. N	0.2005	03375
		Physici /Medio		Decedent's Name (First, Middle, La ROBERT MYRON POT	•					2, Date of De Month	D	18 2005	3. Time of Death 1.25 P M
		Examin		4a. Facility Name (If not institution, giv			4b.	City, Town, o	or Location of Deat	h		c. County of Deati	
				Doctor's Communi				anham	T. 1/11-1-04-11-			rince Ge	
	н	Funeral			Sex 7. Age 1⊠M 2□F	e (In yrs. lası		Inder 1 Year nths Days	If Under 24 Hrs Hours Min.	(Month, D	av. Year	9. Birth	nplace (State or Foreign untry)
		Director		579-28-0798 Usual Residence of Decedent		78				Oct.	19,	1926 Wasi	hington, DC
		yland yland		10a. State 10b. County		10c. City, T	Town or Location	n					10d. Inside City Limits
		th the Marylan or 28a-f show e notified at	ctor	Maryland Prince	George's	New	Carroll	ton					1∭Yes 2☐No
1		or 28	Director	10e. Street and Number			11	of. Zip Code			10g. C	itizen of What Co	untry?
Z		death with the Maryland me 23a or 28a-f show rmust be matified at		6220 87th Avenue				20784				S.A.	
D		lteme	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was	Decedent of I s, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White	
60	36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	№ 1944 1946	10	′es 2∭ No	Specify:			Specify: Wh	ite
K	5-003	2 hou	ed	15. Decedent's E	ducation		16a. Decedent's	Usual Occup	pation		16b.	Kind of Business/I	
(-		hin 7: 9. "n Med	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	(Give kind life. DO N	of work done OT use retire	during most of wo d)	rking	1		,
نو	2121	od wil	Completed		4		Crime I	nvesti	gator		U.	S. Gover	nment
4	p	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last	")				18. Mother's Na		e, Maide	n Sumame)	
2	<u>Ş</u>	Men Men Marke Marke Marke	2	Henry Myron Pott					Nita Jo				
30	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treatmetic event, the Madical Examiner must be retified at ODCs.		19a. Informant's Name/Relationship (Sarah C. Potter			_		and Number or Ri				ip Code) and 20784
		1 and Healt em 2		20a. Method of Disposition	- wile	20b. Plac	e of Disposition	(Name of	1	Date		_ocation - City or	
	Baltimore,	ages ant of t: If it y or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special		cem	etery, cremato	y or other pla	1	2./2005			
	葟	artme orten injur		21. Signature of Funeral Service Lices		Metro	politan 22. Na		ory 1/2 ess of Facility Ga				, Virginia
	B	permi Depar Impo any ir once.		V dlint	May -				imore Av				
		-		23a Panti. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.							Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition			2 /=	1111	PE				Onset and Death
		/Medical		resulting in death)	a. Due to (or as	a consequer	nce of):	17000	76 13				IVENIC
		Examiner		Sequentially list conditions.	b. ART	5K10	SCLON	20110	HBBh.	1 Wisi	IN S	2	5 YBAAS
		pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):						•
	_	be execute sician and burial-tran	хап	that initiated events resulting in death) Last	c Due to (or as:	a consequer	nce of):						
	760,	e be executed rsician and e burial-transit	calE	· ·		, , , , , , , , , , , , , , , , , , , ,							
	687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the			d								
	Box 68	nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						and the state of t	23d. Date of deli	very
	œ.	death	lcla	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1□Live birth 4□Pregnant at 9□Unknown			pic pregnanc er (s <i>pecify</i>) _	у			Month	Day Year
	P.0.	at the by th	hys	9 🗆 Unknown									
	S,	es the	by F	Part II. Other significant conditions	contributing to death bu	ut not resultir	ng in the under	ying cause giv	ven in Part I.			-	the cause of death?
	ord	w requir been si should	ted							1	Yes :	2 □ No 3 □ Pro	obably 4 Unknown
	ec	a law nas b	Completed							24a. Wa auto	psy	prior to c	topsy findings available completion of cause of
	E H	: The cate !	Co							1 Tes	ormed? 2 🌠 N	death?	2□ No
	Vita	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			0*	200	ath (Check only			
	o to	Phys r this ral dii	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatie		VOutpatient 3	DOA	4 Nursing F	lome 5 ☐ Res 28d. Describe		6 □Other (Spec	cify)
	on	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y Year)	Injury	28c. Inju	rk?]Yes 2 □ No	200. 50001150	11044 111)	ary occurred	
	Division of Vital Records,	Atter r dea octor by the	ifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inju	ury - At home	e, farm, street,	actory, office		28f. Location	(Street a	ınd Number or Ru	ral Route Number,
	Ö	el or s afte ol Dire	Certification:	4 Homicide	building, etc	с. (Бреспу)				City or To	own, Sta	f 0)	
		To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	f examination	edge, death occ n and/or investi	urred at the ti	me, date and place	e, and due to the	cause(s) and manner as	stated. to the cause(s)
		thin 2 the I	Medical	one)	and manner sta	ated.							
	}	₹.¥₹.8		255. Organizate and this or contribut	b To L	2	\wedge	17 ()	00589	/		1/20/00	5
	·	. 4		30. Name and address of person who	on lught	loath (ltc= 2)	30) /Time 2:	1 "		1		1	
IT	1/	p.		30. Name and address of person who all the control of the control	CollAM III.) (S	10 K	01/213	127/4 A115	SINTE	341	KIVE	201737
		Sta	ate	31. Date filed (Month, Day, Year)	2. Registra	ar's Signatur	0	•	11/106	10.16	010		36111
		Regist		IAN 2 4 200	3 Dieser	A.	Spare						

		State Registrar	-	artment of Health and rtificate of Death	d Mental Hygi	ene g. No. 2005 13371
Physicia /Medic	al .	Decedent's Name (First, Middle, Last) Mary Cordis Padusi 4a. Facility Name (If not institution, give street and num	harl	4b. City, Town, or Location of De		18, 2005 9:45 p ^M
Examin Funeral	er	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Severna Park If Under 1 Year If Under 24 F	Irs. 8. Date of Birth (Month, Day,	4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Country)
Director Mou		171-26-7511 1	74 Yrs.		Dec. 31	, 1930 Pennsylvania
death with the Maryland ms 23e or 28e-f show Finust be notified at	Director	MD Anne Arundel 10e. Street and Number	Severna	10f. Zip Code	10	1 ☐ Yes 2 No
je 25 1	by Funeral Director	227 McKinsey Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 Yes If Yes, Giv	2 XNo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
filed within 72 hours at Hygiene. ther then "naturel; or int, the Mudical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Give	dent's Usual Occupation kind of work done during most of the DO NOT use retired)	working 1	6b. Kind of Business/Industry
should be filed nd Mental Hygi marked other imatic event, I	To Be Co	17. Father's Name (First, Middle, Last) George Cordis			Name (First, Middle, M	Home (aiden Sumame)
and 2 alth a 27 ie		19a. Informant's Name/Relationship (Type, Print) Peggy Franko/Daughter 20a. Method of Disposition		ng Address (Street and Number or I Ellenham Court	Severna	Park, MD 21146
nit. Page artment o ortent: if injury or e.		12 Burial 2 □ Cremation 3 □ Removal from 9 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Greek Ort	matory`or other place) J	an. 23, 2005	Oc. Location - City or Town, State Woodlawn, MD
Physician /Medical Examiner purial-transit	dical Examiner	23a. ant 1 Enter the disease, in implications that consider the disease in condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (d. d.	or as a consequence of):	erranco & Sons, 25 Gov. Ritchie ler the mode of dying, such as card personal during and during durin	Hwy. Seve:	rna Park Funeral Home rna Park, MD 21146 st. Approximate Interval Between Onset and Death
The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
law requires that as been signed b	by	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2) No 3 Probably 4 Unknown
	Completed	with Aner	una_		24a. Was an autopsy perform 1 Tes 2	prior to completion of cause of
ding Pl	Certification: To Be	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be 28e. Place	patient 2 EP/Outpatien f Injury n, Day Year) 28b. Time of Injury of Injury - At home, farm, st	Other: 4 Nursing 1 Nursing 1 Nursing 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	nce 6 Other (Specify)
To the Hospital or Attenwithin 24 hour after deat To the Funere Lirector: completely filled in by the		4 Homicide building	g, etc. (Specify) bast of my knowledge, deat	th occurred at the time, date and old	City or Town,	State)
To the Hospital or within 24 hour affa To the Funere I vir completely filled in	Medical	(Check only one) 2 Medical Examiner: On the ba and mann 29b. Signature and title of certifier)	sis of examination and/or in	29c. License number	courred at the time, da	d. Date signed (Month, Day, Year)
Sta Begistr		30. Name and address of person who completed cause DR SHOBHA D. REDDY 78.45 31. Date filed (Month, Day, Year) 32.	o of death (Item 23a) (Type, OAKWOO) gistrar's Signature	RO. STC 204 (den Burn	1.20.05 lie MD.21061

11	30		for Stete	State	of Marylar		artment of I			ental Hy	/giene	0005	03277
			Registrer	Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last)							Reg. No.	-000	03377
	Physici	an								2. Date of D Month	Day		3. Time of Death
	/Medic	al	Nancy Lake Rayn 4a. Facility Name (If not institution		washar)		4b. City, Town, o		of Dooth	Janua			8:30a M
	Examin	er	1668 Laugley I		iumber)				or Death			County of Deatl	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Hagers		r 24 Hrs.	8. Date of Bi	irth	ashingto	
	Funeral Director		229-34-7824	1 □ M 2X F	73	Yrs.	Months Days	Hours	Min.	(Month, D	ay, Year)		nplace (State or Foreign untry) land
	p		Usual Residence of Decedent							July 1	J 17.	oi mary	Tanu
	arylar show	ř	10a. State 10b. Count	/	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	8a-1:	Funeral Director	Maryland Washir	gton	Hag	erstow							1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number				10f. Zip Code				10g, Citi	zen of What Co	intry?
	s 23s	eral	1668 Langley D				21740				U.S.		
	Item Item	-un-	11. Marital Status 1 □ Never Married 2 □ Ma	Armed	ecedent Ever in U Forces? s 2 X No	.5.	Was Decedent of I If Yes, specify Cub	oan, Mexica	an, Puerto P	Rican, etc.)	0-	 Race - Amer Black, White 	
336	urs af	by	3 ☐ Widowed 4 X Divorce	If Yes (Give		1 ☐ Yes 2KD No	Specify	<i>y</i> :			Specify:	4
215-0036	within 72 hours after death with the Maryland ane. than "natural, or Items 23a or 28a-1 show ha Madical Examinar must be notified at	Completed	15. Decede	nt's Education	٠, ,	16a. Dece	dent's Usual Occu	pation			16b. Kii	nd of Business/l	iite ndustry
218	thin 7 e.	ple	Elementary/Secondary (0-12)	est grade complete College	(1-4or 5+)	life.	kind of work done DO NOT use retire	auring mo ad)	ist of workin	g			
21	ed wil	Con	12	2	<u> </u>	Homen	aker	,			Dom	estic	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Marical Examinal result be notified at once.	Be	17. Father's Name (First, Middle							(First, Middle		Sumame)	
yla V	Men Men arke	ဥ	James Russell					-		inia E			
Mar	12 sh and is m		19a. Informant's Name/Relation				ng Address (Street						
	1 and lealth		Susan Wood Ha1 20a. Method of Disposition	nes	20h F		'air Mead			agerst		Marylan cation - City or 1	
Baltimore,	in it of h		1 Burial 2 Cremation		m State	semetery, crei	sition (Name of natory or other pla	ice)	06	110	20C. LO	cation - City or i	own, State
Ħ	it. Pi		* 4 □ Donation 5 □ Other (Smi	thsbur	g Creama	tory	1/26/	05	Smit	hsburg 1	Maryland
Ba	permi Depa Impo any ir		21. Signature of Furieral Service	Cipalisas		24	. Name and Addre	ess of Facil	""REST	Haver	Fun	eral Cha	apel
			23a. Part1. Enter the disease, of	r complications tha	t caused the deat							own Mary	yland 21/42 Approximate
6	Diameter .		shock, or heart failure. Lis Immediate Cause (Final	t only one cause or	each line.	,	¥ . ¥	1 1	11	D			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a (^	Lect 7	her she	the	utg	The				
	Examiner			Due	o (or as a conteq	luence or);							
	100	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due t	o (or as a conseq	uence of):							
	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S									
ó	an an rial-tr	EX	resulting in death) Last	Due t	o (or as a conseq	uence of):							
68760,	icate be executed physician and the burial-transit	dlcal		d									
_	ing ph	Ψ.	IF FEMALE:										
Вох	The law requires that the death certificate has been signed by the attending pipage 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregna birth 2 Peta	Ideath 3	Ectopic pregnanc	y			2	3d. Date of deliving	ery Day Year
0.	ne deg the a hed fo	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pre 9□ Uni	gnant at time of d mown	leath 5□	Other (specify) _		<u> </u>			MONIT	Day real
<u>G</u>	es that the de igned by the be detached	Ph	Part II. Other significant condit	ione contributing to	death but not rec	ulting in the u	adachina anuna si	uan in Dart	1	230 Did	tobacco u	no contribute to	the cause of death?
ds,	ires tha signed d be de	by	Part II. Other significant condit	ions continuating to	death but not les	alling in the a	idenying cause giv	ven in Pari	τ.		Yes 2		1.7
Records,	w requir been s should	Completed								-			<u> </u>
Zec	has l	mp								24a. Was		24b. Were autoprior to condeath?	opsy findings available empletion of cause of
a										1 Yes	2 🗆 No	1 Yes	2 □ No
Vital		Be c	25. Was case referred to medical examiner?	Hospital:		55/0	D#			(Check only			At Saana
of	Physic this stal di	2	1 XYes 2 No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatier 28b. Time of	1 3000	4 🗆 14		e 5 L∤Resi 3d. Describe			fy) At Scene
Division	ding Ith. : After funer	tlor	1 □Natural 5 □ Pendi 2 □ Accident invest		onth, Day Year)	Injury	Wo	rk?]Yes 2 🗖		Sutre	its	Later	1
/isi	Attar dea actor	ifica	3 Sui cide 6 □ Could	not be 28e. Pla	ce of Injury - At he	ome, farm, str	<u>'</u>		28	If. Location (Street and	Number or Ruf	al Route Number,
Ö	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Certification:	4 ☐ Homicide determ	buil	ding, etc. (Specif	h	one		f	Lity or 10	wn, State)		angley orme
	bspit hours uners y fille		29a. Certifier 1 Certifyi (Check only 2 Medice	ng Physicien: To t	he best of my kno	wledge, death	occurred at the ti	me, date a	nd place, ar	nd due to the	cause(s)	and manner as	stated.
	in 24 the Fi	Medical	one)		nner stated.	tion and/or in	estigation, in my o	opinion, dea	ath occurred	at the time,	date and	place, and due t	o the cause(s)
	With To T	≥	29b. Signature and title of certific	er .	V		29c. Licens					signed (Month,	
			Theode	M, fe	7 8 m	W)	OCM	1E			Janu	ary 25,	2005
11	H-16		4 4	who completed ca									
2			THEODORE	Milling			Penn St	reet	Balti	more,	Mary	land 21:	201
	Sta	_	31. Date filed (Month, Pay Year	6 2005	Registrar's Signa	iture	1						
	Registr	rar JAN 2 6 2005 Janear B. Courtes											

		ν.		FAmend #19b State of Maryland / Departm			-000	03378
		,		1- State Registra WCHD/SH 1/26/05 per FH Certific 1. Decedent's Name (First, Middle, Last)	ale of Dealif	2. Date of Dea	leg. No.	3. Time of Death
_		Physici		Mildred Ellen RAYMER		Month Jan.	Day Year 24 2005	1:05 a. M
		/Medic Examir			City, Town, or Location of Death	Jan.	4c. County of Death	1:05 4
				Coffman Nursing Home	Hagerstown		Washing	ton
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day)		place (State or Foreign
		Director		220–16–2335 91 Yrs.	Tours IVIII.	Dec. 7		io
		and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1	16		10d. Inside City Limits
		Aaryli f sho	ō					1 ☐ Yes 2 ☑ No
		with the Maryland a or 28a-f show Le notified at	Director	Maryland Washington Hagerst 10e. Street and Number 10	f. Zip Code	1	10g. Citizen of What Cou	
		th with 23a or		20004 Jefferson Boulevard	21740		U.S.A.	,
		er death Itams 2 Det out	Funeral		Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
	ဖွ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madreal Examiner aust be notified at		1 Never Married 2 Married 1 Yes 2√ No	specify Cuban, Mexican, Puerro es 2XNo <i>Specify:</i>	Hican, etc.)		etc.
	203	nours irali,	d by	3 XWidowed 4 ☐ Divorced Year or Dates:			Specify: W	hite
	5-	72 hours "natural"	ete	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Gi	Usual Occupation of work done during most of work OT use retired)	ing	16b. Kind of Business/In	dustry
	21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ook		Board of E	dunation
\		be filed within tal Hygiene. dother than avent, the M		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I		ducation
2	lan		To Be	Benjamin F. Davis	Reulah 1	Ridenour	•	
12	Maryland	d 2 should be filed w th and Mental Hygier 7 ia marked other tl traumatic avent, It.	-		dress (Street and Number of Run nding Oak Dr			(Code) 1 70
g		0 = 2 =		David Raymer - Son 13564 F	emybrook Dr.	Hagersto	wn, Md. 217	42 2174
~	ore	ges 1 and t of Healt If itam 2 or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetary, crematory	(Name of		20c. Location - City or To	
8	<u><u>E</u></u>	nit. Pages lartment of l ortant: If it injury or o	1 1	`4 □Donation 5 □Other (Specify) St. Paul's	$_{\rm S}$ Cemetery $1/25$	/05	Myersville,	Md.
W	Baltimore,	permit. Pages Department of Important: If it any injury or o			ne and Address of Facility Min E. Wilson Blvd			21740
				23a, Part 1, Enter the disease, or complications that you the death. Do not enter the				Approximate
B		Physician		shock, or heart failure. List only one cause or eat line. Immediate Cause (Final	Pour Deleve	2	>10	Interval Between Onset and Death
0	1	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	dy describ			per 1
2		Examiner		Sequentially list conditions by Horabeld	Jensio ky	challs		OTERS
1/2		pe lisit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the year) that initiated events consequence of the year of th	/		Ĭ	
4		The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
	60,	be exician buria						
_	68760	ificate g phys as the	edicai	d				
a	Вох	eath certif attending for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
3	. B	death e atte	Physician/M	in the past 12 months? 1 Vas 2 No. 4 Pregnant at time of death 5 Othe	oic pregnancy er (specify)		Month	Day Year
5	P.0	it the by th tache	hys	9 Unknown		-		
The same	S, F	res that the de signed by the a be detached t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying the underlying to death but not resulting in the underlying to death but not resulting in the underlying the underlying to death but not resulting in the underlying	ing cause given in Part I.		bacco use contribute to the	
d	ord	w requir been si should I		Mynteurion		1 🗆 Ye	es 2 No 3 Prob	ably 4 Unknown
9	Record	ne law r has be ge 2 sh	Completed			24a. Was a autops	24b. Were auto	psy findings available mpletion of cause of
>	_		Con			perform		2 No
2	Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	n (Check only on	те)	
, 70 ll	of	Physi this c	2				ence 6 Other (Specification)	y)
12		ding F h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury	Work?	200. Describe no	ow injury occurred	
×	Division	Attending Physician: ar death. rector: After this certifical by the funeral director.	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street fa		28f. Location (St.	treet and Number or Rura	I Route Number,
ame	Di	al or A	Certification:	4 Homicide determined building, etc. (Specify)		City or Town	n, State)	
Na,		To the Hospital or Atteni within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occur 2 Medical Exeminer: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, ation, in my opinion, death occurr	and due to the cared at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
		To the within 7	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month,	Day, Year)
		- >- 0		SHMUEL CHAN, MID	1)36655	0	TAN 24;	2004
	64	H-4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	tan SI Ha	mort	ala Mix	21740
	9	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	14111 01.11de	10101	(1),1100	21170
		Regist		JAN & D 2000				

Division of Vital Records P.O.

							Cei	tificate o	t Death			Reg. No.	0.5	000000	
	Physici	an	1. Decedent's Name (First, Middl								2. Date of De Month	ath Z U	Year	3: Time of Death	
	/Medic			MIL	DRED	VIOL	ARI	LL				16, 20		9:35 AM	
	Examir		4e. Facility Name (If not institution	-					4b. City, To	wn, or Lo	ocation of Deatl	4c. County	of Death	· J • J J BII	
			LONG VIEW NU	JRSING	HOM	E			MANC	HES	ΓER	CAR	ROLL		
	$_{\iota}$ Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀		je (In yrs. last		If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birth 9. Bir (Month, Day, Year) C			lace (State or Foreign try)	
H	Director		220-26-5937	ILIM ZK	1	89	Yrs.	1,13			MAY 4	ZLAND			
	and *		Usual Residence of Decedent 10a. State 10b. County			10c. City, T	own or Lo	cation						0d. Inside City Limits	
	Aaryli F sho	ត	MD. CARR					BURG					"	1 ☐ Yes 2 No	
	28a-	ect	10e. Street and Number	ОПП		Г	TIME	10f. Zip Code							
	ti se	Ö	1454 WESLEY	ВD				210			10g. Citizen of What Country?				
	eath	Funeral Director	11. Marital Status		Decedent	Ever in U,S.	12 1			ain? (Co.	acife Van au Na	USA	e - Americ	an Indian	
	fter d fner fner	듩	1 Never Married 2 Marr	Arme	ed Forces?		13. 1	Was Decedent of f Yes, specify Cu	ban, Mexicar	n, Puerto	Rican, etc.)	Bla	ck, White,		
7	urs e	þ	3 ☑ Widowed 4 ☐ Divorced	If Ye Year	Yes 2 1 1 s, Give or Dates:		1	I□Yes 2XDN	Specity:			Specif	v: WH	ITE	
5									16b. Kind of B						
<u>'</u>	15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)							,							
7	filed wit Hygiene ther the	Completed	8		igo (1 401 t	J+)	S	EAMSTR!	ESS			MANUF	ACTU:	RING	
2	be file Ital Hy d othe	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Surnan	ne)		
<u>a</u>	should be filed withir nd Mental Hygiene. marked other than imatic event, the Ma	2		MARSH	ALL 1	FILLMO	ORE :	KNIGHT	AM.	ANDA	A	TAYLOR			
g	should and Men smarke sumatic		19a. Informant's Name/Relations	hip (Type, Print)	1	9b. Mailin	g Address (Stree	et end Numbe	er or Rura	al Route Numbe	er, City or Town,	State, Zip	Code)	
E	and and a salth		ROY L. RILL	_	SON	1	16 J	ACKSON	RD.,	GET	TYSBU	RG, PA	. 1	7325	
ט כ	of He		20a. Method of Disposition	o □ o		20b. Place	of Dispos	sition (Name of natory or other pi			Date	20c. Location -			
	Pages nent of I int: If ite iry or o		1 ⊈ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		rom State		-	EMETER		1/	20/05	HAMPST	EAD.	MD.	
Ĕ	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any Injury or other traumatic once.		21. Signatur Hull and Service	Licensee			22	. Name and Add	ress of Facilit						
3	82 5 8 9		N VIII				25	4 E. M	AIN S	т.,	WESTMI	NSTER,	MD.	21157	
			23a. Part1. Enter the disease, or shock, or heart allure. List	complications t	hat caused	the death. D	o not ente	er the mode of dy	ing, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between	
	Physician		STOOK, OF FIGURE CHUTS. Elst	only one cause	OII BACITIII	1		, +					i	Onset and Death	
	/Medical		Immediate Cause (Final disease or condition			16	+2	him and.	w-1	1		2	I I	10 Years	
	Examiner		resulting in death)	θ		Due to (or as	a consequ	uence of):			1		1		
-	sit s	ine		- h											
	and I-tran	Examiner	Sequentially list conditions, if any leading to immediate		7.	Due to (or as	a consequ	uence of).					1		
ָבָּ ב	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunel-transit		Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C											
Š	phys the	an/Medical	that initiated events resulting in death) Last			Due to (or as	a consequ	uence of):							
<	certif ding Ise a	Š		d											
á	atter for L	clar											1		
į	the d	Physici	Part II. Other significant condition	ns contributing	to death bi	ut not resulting	g in the un	iderlying cause g	iven in Part I.					the cause of death?	
	Attending Physicien: The law requires that the deal death. ector: After this certificate has been signed by the att by the funeral director, page 2 should be detached to	by P									10	Yes 2 No	3 Prob	ably 4□ Unknown	
3	luires n sign	8									24a, Wes	en autopsy	24b. Wai	re autopsy findings	
3	A red	Completed									perfo	rmed?	ava	ilable prior to	
2	e has	ᇍ												eeth?	
•	n: Ti ficate or, pa		25. Was case referred to medical									es 2 No	1 🗆	Yes 2□No	
	Physician: The this certificate ral director, pag	o Be	examiner?	Hospital:	1 🗆 Inpatie	et aften	Outantiant	3□ DOA O	her:	_	(Check only o				
5	Phy erthis	-	27. Manner of Death		ate of Injui		. Time of	28c. Inju				lence 6 Other)	
)	tf: .: Afte	읉	Natural 5 ☐ Pending 2 ☐ Accident investig		Month, Day	Year)	Injury		ork?]Yes 2.∐1	Vo.					
2	Atte	150	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 280. P	lace of Inju	ry - At home,	farm, stre	et, factory, office)	2	28f. Locetion (S	Street and Numb	er or R urel	Route Number,	
	s effe	Certification:	4 - Hornicide		uliding, etc	c. (Specify)					City or Ton	m, State)			
	uner uner		29a. Certifier Certifying	Physicien: To	the best of	of my knowled	ge, death	occurred at the t	ime, date and	place, a	nd due to the o	euse(s) and ma	nner es sta	ited.	
		Medicai	A .	and i	manner sta	ited.	ariu/or Inve	estigation, in my		n occurre	o at the time, o	rate and place, a	and due to	me cause(s)	
	Neit Co	Σ	29b. Signature and title of certifier						se number			29d. Date signed	(Month, D	lay, Year)	
	المتالم								7221	(c c)		1	18	05	
	2		30. Name and address of person v	who completed	_					2	<u> </u>	1.1)	1 2 2	
			31. Date filed (Month, Day, Year)	~) \c	2 Registra	ar's Signeture		. Home ?	-	or he	- 4/6	mots of	ea (v	~ < 211014	
	Stat Registra			0 2005	Z. Hogista		K	frank .				1			

OTis SAVage 230-18-0730 Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Uage ST s 4b. City, Town, or Location of Death /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday)
Yrs Medical Center egional Willmill 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** 12 M 2 F Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show Exeminer must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 233 Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ever in U.S. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "naturel", lack other treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 3 2 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) nechani 17. Father's Name (Firşt, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If item 27 is any Injury or other treum Pages 1 and 2 s ment of Health an Salisbury Getma 208. Place of Disposition (Name of Urbaia 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Crer 3 Removal from State 4 Donation 5 Doher (Specify) Jerusalem emperon ce VIIIc 22. Name and Address of Facility 21. Signature of Funeral vice Licensee Fun oral P.O. Bax 331 po comoke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** terozo m disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner en Sequentially list conditions, I any leading to minimal acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 No 1 TYes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1. Inpatient 21 No 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 61827 22/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100E CARROLL ST. SALISBURY Md Kmc · SIVAKUMAR RAMAN MD 31. Date filed (Month, Day, Year) Pagistrar's Signature JAN 2 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** AUDREY MALISSA JACKSON SMALL 01 2005 7:35 P 18 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 32393 GREENFIELD COURT WORCESTER POCOMOKE CITY It Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours POCOMOKE, MD. 1 ☐ M 2 및 F Yrs Director 92 06-03-1912 220-32-0852 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director MD WORCESTER POCOMOKE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32393 GREENFIELD COURT 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER & OPERATOR POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 is marked off jury or other traumatic even Be JOSEPH STANLEY JACKSON EVA MARINER ျှ 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MALISSA WILSON - DAUGHTER 32393 GREENFIELD COURT, POCOMOKE CITY, MARYLAND 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, State Important: If It ony injury or o once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 01-20-2005 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. permit. Departr 21. Signature of Funeral Service Licenses 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** /Medical resulting in death) Examiner SCL Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence ot): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetet death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed I Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01-20-05 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8th anti Year) 31. Date tited (Month) 32. Registrar's Signature State 0 2005 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

	State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene Reg. No. 2005 03382
Physicia /Medic	I BIOCHARET	January 23, Year 0 5 4:50pm
Examine	Williamsport Nursing Home William	The standy of standing
Funeral Director	5. Social Security Number 215-36-6264 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Min.	8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country) MD MD
after deeth with the Maryland or Items 23a or 28a-f show infinet must be notified at	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Washington Williamsport	10d. Inside City Limits X□ Yes 2□ No
th with th	10e. Street and Number 154 N. Artizan St. 21795	10g. Citizen of What Country? U.S.A.
1215-0020 within 72 hours after deeth with the Maryland and and returnal, or items 23s or 28s-f show he Macical Exercities must be notified at	MD Washington Williamsport 10e. Street and Number 154 N. Artizan St. 11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 th grade Williamsport 10f. Zip Code 21795 13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto Pear or Dates: 15. Decedent's Education (Give kind of work done during most of work life. Do Not use retired) Homemaker	pecify Yes or Noo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0020 d 2 should be filed within 72 hours aff th and Mentel Hygiane. 7 is marked other than "natural", or traumatic event, the Medical Exert	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade 16e. Decedent's Usual Occupation (Give kind of work done during most of work form of work done during most	king 16b. Kind of Business/Industry residence
aryland should be file ind Mentel Hy marked oths umatic event,	17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, Maiden Sumame) Carbaugh
	19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rul	ral Route Number, City or Town, State, Zip Code) ike Clear Spring, MD 2172
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item 2 smy Injury or other page.	20a. Method of Disposition 1 Degrate 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Little Rose Hill 200	6 Date 20c. Location - City or Town, State
Balt permit. Depart Import any inje	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Th	ompson Funeral Home, Inc
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A PREATION PREMIMONIA Due to (or as e consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
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COTOS, P.O. BOX v requires that the death carl been signed by the ettendin should be datached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
E Be de de de de de de de de de de de de de		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
TO A SON E		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
VITAL Islclan: The certificate irector, pa		n (Check only one)
그 살 하는 그	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
DIVISION OT balor Attending Physics after deeth. al Director: After this led in by the funeral di	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
the Hospital iin 24 hours of the Funeral I pletaly filled		and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
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	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)	JANUARY 25, 2005
3H-2	TED HOWE 154 N. ARTICAN ST. WILLIAMSPORT	T, MD
State Registrar	31. Date filed (Month, Ray, Yeer) 6 2005 32. Begistrer's Signature	

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	-	partment of I	Health and Me	ental Hygie	C	00000
	Dharaini		1. Decedent's Name (First, Middle, Las	t)			2	2. Date of Death Month	Day Year	3 Time of Death
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	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	
			19727 SHILOH C				STOWN		WASHIN	
	Funeral Director		5. Social Security Number 6. Se 219 – 36 – 3452	TVM OFF	(In yrs. last birthda 64 Yrs.	y) If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye IARCH 9.	9. Birth Cou	place (State or Foreign ntry) MARYLAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					
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	leath w	Funeral	11. Marital Status	12. Was Decedent E				ifv Yes or No-	U.S.A.	
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036	al', o	by	3 ☐ Widowed 4 ★ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X No	Specify:		Specify: WH	ITE
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	na Ho na Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner state	examination and/or	investigation, in my	opinion, death occurred	at the time, date	and place, and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	0 .		29c. Licen			Date signed (Month,	
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Λi	í1. <i>Í</i>		30. Name and address of person who c				errace Ro			, Md.21742
(b)	Α ∘ Γ Sta	te	31. Date filed (Month, Pay Year) 6		r's Signature		01100 110	aa, na	3 2 2 0 0 WII	,
	Regist	ar	UANAU	LUUU BELL	m B.	opere				

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			1 - State Amend Item Registrar		Marylan G840	d / Depa 2-24-0 Cei	rtment of tas tificate o	f Health a of Death				005		384	
п	Physicia	98	Decedent's Name (First, Middle						2	2. Date of Dear Month	Day	Year	3. Time o	of Death	
	/Medic	al	4a. Facility Name (If not institution	Joseph:		Samso		n, or Location of	of Death	Januar		2005	7:30	Α. Μ	
	Examin	er	Anne Arundel	-				apolis			1	Arun	de1		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Ye Months Dar	ar If Under	24 Hrs. 8	(Month, Day, Year) Country					
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ore	0 0		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 □Removal from Sta		lace of Dispo emetery, crea	sition (Name of matory or other	f place) (01-27-	te -0.5	20c. Locatio				
Baltimore, Maryland 21215-0036	Pages tment of I tant: If its		' 4 □ Donation 5 □ Other (S)	oecify)	La		Memori	al Gard	dens	D	avidso	onvill	e, Md		
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9 x	death certifica attending ph for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	incy					23d I	Date of deliv	env		
Box	death	iclar	in the past 12 menths?	4□Pregnar	h 2∏Feta nt at time of d		⊒Ectopic pregna ⊒ Other <i>(specify</i>					Month	Day	Year	
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Vital Records, F	sign d be	by	Part II. Other significent condition	ons contributing to dea	th but not res	ulting in the u	inderlying cause	given in Part I	l. 	23e. Did to	bacco use co es 2 2 No		the cause of bably 4		
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١	my		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type,	Print	- , L.	D.11	A	0000	ah.	mh		
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			1 - For State Registrar	State of Ma	arylan	d / Depa		t of H	ealth a		lental Hy		e 20	0.5	033	300
	Physici		Decedent's Name (First, Middle, Last	,	stine	Ann S	Sherma	n			2. Date of Do Month Janua	D	ay 18, 2	Year 2005	3. Time of 6:00	
	/Medio		4a. Facility Name (If not institution, give Larkin Chase Nur	street and number)			4b. City,		Location o	f Death		4	c. County	of Death		
	Funeral Director		5. Social Security Number 6. Se			last birthday) Yrs.	If Under Months		If Under : Hours	24 Hrs. Min.	8. Date of Bi (Month, D Sept.			9. Birthp	lace (State of htry)	r Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Prince G	eorges	10c. City	y, Town or Lo	cation Bowie							1	0d. Inside Cit	•
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinal be fooling at ADR.	by Funeral Director	7104 High Bridg 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Was Deced if Yes, spec	ent of Hi ify Cuba	spanic Orion, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		14. Race Blac	e - Americ k, White, Whi		
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Baltimore,	mit. Pages partment of h cortant: if ite / injury or of		1 Surial 2 Cremation 3 1 Donation 5 Other (Specify 21. Signature of Funeral Service Licent	')	- 1	lace of Dispo emetery, crer • Linc	oln C	emet	ery	1/22	2/2005 111 Fun	Bre	entwo	od. N		nd
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P.O. Box 6876	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	Ideath 3	Ectopic pre				,		23d. Date Mor	e of delive	,	'ear
	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions of Advanced	ontributing to death b	ut not resi	ulting in the u	nderlying ca	use give	en in Part I.		0.0				e cause of de	
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Division	al or Attending s after death. il Director: After id in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined								28f. Location City or To			er or Rura	l Route Numb	ner,
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	Sta Regist	até rar	14300 C 31. Date filed (Month, Day, Year)	32. Aegistr	ar's Signa	tyre Ap	ali	V _c .	104		30 Cm	-				

State of Maryland / Department of Health and Mental Hygiene 2 03386 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SCOTT WILLIAM LINWOOD 8:05 AM 17,2005 January /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Ctr. Cheverly

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Prince George 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1□**M** 2□ F Director 229-20-7778 81 Feb. 14,192B VA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rai', or items 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 □ No Prince George Seat Pleasant Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 731 Carrington Place 20743 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1943 to If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be tiled within 72 hours after Health and Mental Hygiene. em 27 ts marked other than "natural", or ite 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: B1 acl δ 3

Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than W Elementary/Secondary (0-12) College (1-4or 5+) U.S. Gov't. Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Scott Irene Gilmore ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 731 Carrington Place, Seat Pleasant, MD 20743 permit. Peges 1 and 2 s
Department of Health ar
Important: If item 27 ts
eny injury or other trau Linda C. Scott-Ellis/Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 142 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Fill Cenetery 1/24/2005 Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Hore, Inc. 21. Signature of Funeral Service Licenses 14111 Pennsylvania Ave. Suitland, MD 20746 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, syck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nei 1m 0 . /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or all a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Atter this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation hours after death tilled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 00057039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4404 Queensbury Rd, Riverdale, MD 20737 M.D. Babak FAT 31. Date filed (Month, Day, Year) State 2005 Registrar 4

		For State	State	of Marylan		artment of H		d Mental Hy	_		00000		
		Registrer 1. Decedent's Name (First, Middle	Last)		Cer	uncate or	Dealli	2. Date of D	Reg. No	<u>: UU5.</u>	3. Time of Death		
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Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of D		4c. County of Death				
		Montgomery Gene		,		01r	_	Use I	Montgomery				
Funeral Director		5. Social Security Number 226-76-3579	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs.	86 Yrs.	Months Days		Min. 8. Date of B (Month, D Feb. 1	ay, Year)	9. Birt Co	hplace (State or Foreign untry) Maica		
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ems S	ner	11. Marital Status	12. Was De Armed F	cedent Ever in U.	S. 13. V			? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Ame Black, White			
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and 2 and 2 ealth a n 27 is			(Daughte			Mystic C		Olney, MD	208	332			
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Dall LIMO permit. Pages Department of Importent: If it eny injury or o		* 4 □ Donation 5 □ Other (Single 21. Signature of Funeral Service		Ga		Heaven C		/27/05		ver Spri	.		
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6		290. Signature and this account	100 -1	2003		D	0505	745	2	1/21	12004		
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State

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

Physician	
/Medical	
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Eratrical must be notified at once.

Name: Schmidt He Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit WJL 10

Henry Alwin Schmidt Jr. 46. Chy Tenr, or Location of Death Receder's Memorial Home Receder's Memorial Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Recently Receder's Receder's Recently Receder's Recently Receder's Recently Receder's Receder's Recently Receder's Receder's Recently Receder's Recently Receder's Receder's Recently Receder's Receder's Receder's R		1 - For State Registrar	State of Marylan		tificate of			Reg. No	21105	0338			
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FFEMALE: 23b Was decodent pregnant 1 Live birth 2 limited idealth 1 Lives 2 link 3 limited 2 limited 3 limited 2 limited 3 limit	cai Exam	that initiated events resulting in death) Last C											
25. Was case referred to medical examiner? 1													
25. Was case referred to medical examiner? 1	ysician//	23b. Was decedent pregnant in the past 12 months? 1 \subseteq Yes 2 \subseteq No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ldeath 3 □		су							
25. Was case referred to medical examiner? 1	y Ph	Part II. Dther significant conditions con	tributing to death but not res	ulting in the ur	derlying cause g	ven in Part I.	23e. Did t	obacco u	use contribute to t	he cause of death?			
25. Was case referred to medical examiner? 1	q p	end-stage de	merilia	***			1 🗆 1	Yes 2	□No 3□Proi	bably 4 Unkno			
25. Was case referred to medical examiner? 1	siete								24b. Were auto	opsy findings availa			
25. Was case referred to medical examiner? 1	mo						perfo	rmed?	death?				
Continue Continue	O					26. Place of Dea							
27. Manner of Death	.0	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	ER/Outpatien	3□ DOA O	her: 4 Nursing H	lome 5 Resi	dence	6 ☐Other (Special	fy)			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 21 Wyand Dr., Keedysville, MD 21756 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1 Natural 5 ☐ Pending			Wo	ork?	28d. Describe	how injur	ry occurred				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 21 Wyand Dr., Keedysville, MD 21756 301-432-2222 31. Date filed (Month, Day, Year) 32. Registrar's Signature	edicai	(Check only 2 Medical Examir	10r: On the basis of examina	wiedge, death tion and/or inv	occurred at the livestigation, in my	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) date and) and manner as s d place, and due t	stated. o the cause(s)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 21 Wyand Dr., Keedysville, MD 21756 301-432-2222 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ž	29b. Signature and title of certifier						29d. Dat	te signed (Month,	Day, Year)			
Dr. Robert Guedenet 21 Wyand Dr., Keedysville, MD 21756 301-432-2222		My al			033	2518		1/20	105				
31. Date filed (Month, Day, Year) 32. Registrar's Signature		30. Name and address of person who co Dr. Robert Guedene	mpleted cause of death (Item et 21 Wyand D	n 23a) (Туре, r., Kee	edysvill	e, MD 217	56 30	1-43	2-2222				
JAN & I COURT IF ROLL B	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 19, 2005 **Physician** Year Theresa F. Tyler 9:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 30, 1925 Birthplace (State or Foreign Country) Days Months 578-26-5903 1 M 2 XF **79** Yrs Wash. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Rockville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White ģ Specify: 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Bowles Not Available 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rev.Christie Hughes-Executor- 9701-Veirs Dr., Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Mem. Gardens-1/24/05 Dunkirk, Md. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service Licensee 22. Name and Address of Facility 1.3 Hysong Co., Inc. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disease of shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) urosepsis days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of)

Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Division of Vital Records, P.O. Box 68760, attending physic signed by the a within 24 hours after death. To the Funeral Director: A filled in by the completely

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ne 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 □Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co diabetes mel	litus	sulting in the underlyi	ng cause given in Part I.		acco use contribute to the cause of death?
renal failu	re			24a. Was an autopsy perform	prior to completion of cause of death?
25. Was case referred to medical examiner?	Hospital: Inpatient 2	ER/Outpatient 3		of Death (Check only one sing Home 5 Resider	oce 6 Other (Specify)
27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe how	vinjury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fa	ctory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
29a. Certifier (Check only one) Certifying Phy	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investiga	rred at the time, date and tion, in my opinion, death	place, and due to the can n occurred at the time, da	use(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier Plicia J	Mistage	MD	29c. License number D 59738		d. Date signed (Month, Day, Year) anuary 19, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alicia T. Mistry 9901 Medical Center Drive Rockville, MD 20850

31. Date filed (Month, Day, Year)

4 2005

HICIAT. MISTRY

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

State Registrar

DHMH 17 Rev 1/2001

JAN 2 4 2005



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 💪 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0547 Bill Ρ. Williams **JANUARY** 20 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Legional Medical WICONICO Age (In yrs. last birthday, Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1**∑** M 2□ F Director Virginia 236-36-6715 Usual Residence of Decedent July 19, 1925 the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Items 23a 1315 Hamilton Street Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Army If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Year or Dates: nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other the eny injury or other treumatic event, the once. 12 Factory Worker Crown, Cork & Seal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Williams 2 Mable Corum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Lee Grimsley Williams (wife) 1315 Hamilton Street, Salisbury Maryland 21804

20a. Method of Disposition

1 | Burial 2 | Cremation 3 | Bernoval from State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 M Other (Specify) Entarbarent Springhill Memory Gardens January 24, 2005 Hebron, Maryland 21. Signature of Funeral Service Licent 22 Name and Address of Facility Home Professional Association 501 Snow Hill Road, Salisbury, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown iis certificate has been si director, page 2 should l Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A
filled in by the for 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 2 450497

DHMH 17 Rev 1/2001

State

Registrar

36

of death (Item 23a) (Type,

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completed ca

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20/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sylvia Ruth White TAN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner egional Medical Center 8. Date of Birth (Month, Day, Year) NOV - 28 19 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 F Days Months Hours Min 212-72-1679 45 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a State 10b. County Completed by Funeral Director Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 401 c Trinity Drive 21801

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

James F.Greene

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No

If Yes, Give Year or Dates:

College (1-4or 5+)

Reg. No.-

Day

2005

WICOMICO

1959 Delaware

14. Race - American Indian. Black, White, etc.

Black

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

Month

U.S.A

None

18. Mother's Name (First, Middle, Maiden Sumame)

Essie C.Palmer

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

1 Yes 2 No

Domestic

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

17:09 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 and 2 should be filed within 72 hours after o Health and Mental Hygiene. 8m 27 is marked other than "natural", or iter Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health a Important: If itsm 27 is any injury or other trav

Be

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Examiner

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Completed

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Certification;

Medical

Physician /Medical **Examiner**

burial-transit Physician/Medical

this : After t or Attending death. To the Hospitei within 24 hours a To the Funerei D

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 614 Spring Garden Ave. Salisbury, Md. 21801 Kelly Wallace (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 22/05 Springhill Mem.Garden 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Md. 21. Signature of Funeral Service Licensee Stewarteruneral Home Gladys B. West Rd.Salisbury Md.21801 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a or ns- uence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Phpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medicel Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and paginer stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie 29b. Signayura se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

State

32. Resstrar's Signature

JAN 2 0 2005

Physician	•	RegistratWCHD/SH	1/26/05 p	erFH	Certificate of	Death WCHD	SI PEReg. No	1/2//2/05	
	1	. Decedent's Name (First, Middle,	Last)				Date of Death Month Da	y 25 Year	3. Time of Death 5 0850 A.M
/Medical	-	Marsha Lorraine			Ab Ciby Tourn	or Location of Death	anuary.	. County of Deat	
Examiner	4:	a. Facility Name (If not institution, g Washington Cour		_	Hager			Washing	
uneral	5			ge (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth (Month, Day, Year)		hplace (State or Foreign untry)
irector		071-38-4375	1□M 2☑F	7-58	Yrs. Months Days		arch 23,1		w York
>	-	Isual Residence of Decedent Oa. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
Containing to result and western regions. The modified at some 23a or 28a-f show important: If time 27 is marked other than "neturel, or lease 23a or 28a-f show any injury or other treumatic avent, the Medical Examinar must be radified at once. To Be Completed by Funeral Director			atan						1 √2 Yes 2 □ No
28a-	1	Maryland Washin Oe. Street and Number	gton	nage.	rstown 10f. Zip Code		10g. Ci	tizen of What Co	untry?
		13812 Pennsylva	ania Avenue		2174	2		USA	
sample must be multiled by Funeral Director	1	1. Marital Status	12. Was Deceden	Ever in U.S.		Hispanic Origin? (Speci ban, Mexican, Puerto Ric		14. Race - Ame Black, Whit	
Fu II		1 ☐ Never Married 2 🛣 Marrie			1 ☐ Yes 2 ₩ No		July 010.7	Specify: B1	
d b		3 Widowed 4 Divorced	Year or Dates:				4.01 16		
Completed		15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retir	durina most of working		(ind of Business/	industry
m duc		Elementary/Secondary (0-12)	College (1-4or		cretary	,	C1.	erical	
Be Co	1	7. Father's Name (First, Middle, La	ast)	, 50	crecary	18. Mother's Name (
atic av		Ira Powell Sr				Vera Est	elle Jack	son	
uma		19a. Informant's Name/Relationshi	р (Турв, Print)	19b	Mailing Address Stree	et and Number or Rural R	Route Number, City	or Town, State, I	Zip Code) IV 11706
er tre		Keisha Wallace	Kecia Wal	llace 13	56 North Ca	rdiner Dr.	Bay Shore	, New Y	ork 11706
or of	2	0a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	3 □Removal from State	cemeter	Disposition (Name of y, crematory or other pl	2/1/0		ocation - City or	Town, State
<u>iu</u> y		' 4 □ Donation 5 □ Other (Spe		Oakwo	od Cemetery	1/29/	2005 Bay	Shore,	New York
any in		21. Signature of Funeral Service Li	censee			ress of Facility Rose			. 1170 <i>c</i>
	+	23a. Part 1. Enter the disease, or c	omplications that cause	ad the death. Do		h Avenue, N		Snore,	Approximate
		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each	ine.	+ 0	ancreat	Ca	ncer	Interval Between Onset and Death
cian dical	- 0	disease or condition resulting in death)	a. Dua to (or a	s a consequence	of\:				F 11 1 1
iner			R	< hal	Failur	~ _			
je je		Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury	b. Justo (or a	в а сопезиционся	of):				
Unial-transit		that initiated events	c						
EX		resulting in death) Last	Due to (or a	s a consequence	of):				
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	-	IF FEMALE:	23c. If yes, outcom	a of progpancy				004 Data at do	
Med	-	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death at time of death		су		23d. Date of de Month	Day Year
for use as			4 Lift Teginani		5 □ Other (enecify)				
for use a		1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		5 ☐ Other (specify)				
detached for use as						given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
be detached for use as	2 ,	9 🗆 Unknown				given in Part I.	23e. Did tobacco		
be detached for use as by Physician/Me	2 ,	9 🗆 Unknown				given in Part I.	1 ☐ Yes 2	2 □ No 3 □ P	robably 4 Unknow
no set of the set of t	2 ,	9 🗆 Unknown				given in Part I.	1 Yes 2 24a. Was an autopsy performed?	24b. Were all prior to death?	robably 4 Unknow
e 2 should be detached for use a	fa paradillos a	9 ☐ Unknown Part II. Other significant condition				given in Part I. 26. Place of Death (1 Yes 2 24a. Was an autopsy performed? 1 Yes 2	24b. Were all prior to death?	robably 4 Unknown utopsy findings available completion of cause of
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	Funeral Director		5. Social Security Number 217–30–0847 Usual Residence of Deced	1[x □M 2[X]F	7. Age (In yrs	s. last birthday)	If Unde Months	n 1 Year Days	If Under: Hours	Min. Sept	8. Date of B (Month, E ember	irth Pay, Yea 9,1	934 M	9. Birthp Cour laryl	elace (State or etry) and	Foreign
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altin	permit. Pages Department of I Important: If its any injury or o		*4 □ Donation 5 □ C 21. Signature of Funeral S			St	.Marys			em s of Facilit		05	Bry	antow	n,Ma	ryland	
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rds, P	The law requires that the te has been signed by thi rage 2 should be detache	by	Part II. Dther significant of	conditions co	ontributing to de	eath but not re	esulting in the u	nderlying	ause give	en in Part I.			tobacco			ne cause of de ably 4 □Ur	
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Vital	ilcian: Th certificete rector, pag	Be	25. Was case referred to examiner?	-	Hospital:				Othe			(Check only					
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Division	al or Attendi after death. I Diractor: A d in by the fu	Certification:		Could not be determined	286. Place	of Injury - At ng, etc. (Spec	home, farm, st	reet, factor	y, office		2	8f. Location City or To			or or Rura	l Route Numb	PB <i>r</i> ,
	To the Hospital or Att within 24 hours after of To the Funaral Diract completely filled in by	edicai C	29a. Certifier 1 C (Check only 2 M	Certifying Phy ledical Exam	iner: On the b	best of my kr asis of examir ner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	nd due to the	e cause(e, date a	s) and mar nd place, a	ner as st	ated. the cause(s)	
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(25		PACE, ROB	ERT T	completed caus	se of death (Ite	om 23a) (Type,	Print) INE	CENT	TER V	VALD	ORF.	MD	2060	2		
	Sta Registi		31. Date filed (Month, Day		32 B	estrar's Sign						,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:30 AM Jr. January 20, 2005 Gary Weems /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince Georges Upper Marlboro 9612 Croom Road Upper Mar Locio

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Str. Country)

Months | Days | Hours | Min. | December | 23,1930 | Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** XXM 2□F 74 **Director** 220-28-5968 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Modical Exercitivet must be notified at 1 X Yes 2 □ No Director Upper Marlboro Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20772 9612 Croom Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? 1952-1 XYes 2 □ No 1953 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) Off Set Press Operator Board of Education 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be item 27 is marked o Susie P. Spencer Sr. E. Weems Gary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Weems/Wife 9612 Croom Road Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State - E ö permit Page Department of Important: If any in ury or once. Cheltenham, Maryland Maryland Veterans Cem 1/31/05 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee)clessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) MOS Physician /Medical (or as a consequence of): Examiner Sequentially list canditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnj 3 Ectopic pregnancy Year Month Day in the past 12 moo 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ension 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 1 ☐ Yes 2 🗓 SIL 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified January 21, 2005 052503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print, 1221 Mercantile Lane Largo, Maryland 20774 Shailesh Sheth, MD 32. R Mrar's Signature 31. Date filed (Month, Day, Year) State 2005 **JAN 2 4** BUSI. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January Douglas Wray .Jr. ŹĨ, 2005 Leon 6:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7840 Tall Oaks Place Charlotte Hall Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | July 7, 1959 | WashingtonDC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F 577-90-3351 Yrs Director 45 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits 28a-f show other traumatic event, the Madical Exercities must be notified at MD Charles Charlotte Hall 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 Tall Oaks Place 20622 or Items 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, Ite Mudic. Exertine 1006. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify: 3 Widowed 4 NDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Barbering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Douglas Leon Wray, Sr. Cynthia Houghton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20622 Cynthia Cooley/Mother 7840 Tall Oaks Place, Charlotte Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State *4 □Donation 5 □Other (Specify) Brinsfield-Echols Cr.1/22/05 Charlotte Hall,MD 21. Signature of Funeral Service Licenses BRINSFIELD ECHOLS FUNERAL HOME, P.A. 20622 W Cur Three Notch Rd. Charlotte Hall MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) an (res Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death Month Day signed by the a d be detached f 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes **2**€ No Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Ansidence 6 Other (Specify) 1 ☐ Yes 2 🔀No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury Natural s after dee... ral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 person who completed cause of death (Item 23a) (Type, Print) 0 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 4 2005 Registrar

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month LAURENCE JOSEPH WELSH 15, JAN. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**⊠**M 2□F Director 257-10-9836 Yrs. 86 11/11/1918 FRANCE Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is markad othar than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Exact as must be notified at 10d. Inside City Limits Directo MD. CARROLL LINWOOD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3885 WATSON LANE 21791 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ճ Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic avent, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) BROKER REAL ESTATE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LAWRENCE PATRICK WELSH JOSEPH LePEDEREL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHRYN WELSH - WIFE 3885 WATSON LANE, LINWOOD, MD. 21791 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State WESTMÎNSTÊR CEM. 1/19/05 WESTMINSTER, MD. ` 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFLETCHER FUNERAL HOME ature of gray Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscieroric chorocornic hoecoe **Physician** 2 yen /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DECIPHERAL VASULAR DISCASE 1 No 3 Probably 4 Unknown Completed NOW insular dependent dicibels mellily 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cell chreimons performed SGRAMCEL Division of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Enpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JOL45 TY D31660 17 2005 Some 4+14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4115 GALVINTI TITOMAS 291 STONER AVENUE WOOTH WITH MANULUS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Olow & Sparke Registrar JAN 1 9 2005

		For State of Maryla 1 - State Registrer		rtment of H tificate of L			iene2005	03401
Physicia	an	1. Decedent's Name (First, Middle, Last) Robert Stanley Whits	on			2. Date of Deat Month January	h Day Year	3. Time of Death 3. Time of Death
/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	dandar y	4c. County of Dea	<u>- </u>
Funeral Director		16 Pennsylvania Ave., Apt. 4 5. Social Security Number 6. Sex 7. Age (In yr 2) 7 232-76-3621 55	s. last birthday) Yrs.	We If Under 1 Year Months Days	stminster If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 27	Carrol 9. Bi	Thplace (State or Foreign country)
_		Usual Residence of Decedent	City. Town or Loc	eation			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
Aarylau F ahov	ō	Maryland Carroll		westmins	+ 0 "			1 No
r 28a-	Director	10e. Street and Number		10f. Zip Code	LEI	10	0g. Citizen of What C	country?
th with		16 Pennsylvania Ave. – Apt.			21157		U.S.A.	
titled within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene wither then "natural", or Items 23a or 28a-1 ahow ant, the Marical Example of the notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	i i	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 → No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
2 hour		15. Decedent's Education	16a. Decede	ent's Usual Occupa	ation during most of work	ina	16b. Kind of Busines	
be filed within 7: ital Hygiene. id other than "n event, the M. ii	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 1	life. D	laborer	uring most of work.	ing	constru	ction
- o = 0 ×	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, A	Maiden Surname)	
should be ind Mental i markad c	To	L. Stanley Whitson					kelberger	
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) Rev. L. Stanley Whitson/ father					City or Town, State, ninster, M	
s 1 and if Health item 27 other tr	9	20a. Method of Disposition 20b	. Place of Dispos				20c. Location - City o	
Pages tment of tant: If it			11 Count	y Cremat	ion 1/17/		Sykesville	•
permit. Pages 1 and 2 should be Department of Health and Mentis Important: If item 27 is markad any injury or other traumatic e once.		21. Signal for 1 Furgoral Service Licensee	22.	10 Churc	h St. N	tzler Fu lew Winds	uneral Hom sor, MD 21	e 776
		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	()					minatrs
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icate be executed physician and sthe burial-transit	edical E	d						
ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
uires that the de signed by the a	δ	Part II. Other significant conditions contributing to death but not it	esulting in the un	derlying cause give	en in Part I.			to the cause of death?
he law require has been singe 2 should b	Completed					24a. Was ar autops perforn	y prior to neg? death?	autopsy findings available completion of cause of
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Physic this ce al direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2			4 Nuising no		nce 6 Other (Sp.	ecify)
or Attending Physician: The after death. Director: After this certificate his by the funeral director, page	atlon:	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe ho	w injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funn	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (St City or Town	reet and Number or F I, State)	Rural Route Number,
e Hospil 24 hour e Funera etely fill	dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my keep conditions and manner stated.	rnowledge, death ination and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens	e number	29	9d. Date signed (Mor	nth, Day, Year)
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3		30. Name and address of person who completed cause of death (I	1 2973 4	nauches!	e Ru ma	incheyte.	mn 211	02
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signary Sig	gnature	Sparke				

		•	For Stete Registrar		State	of Mar	ryland			nt of He te of D			ental Hy	gien Reg. N		05	03402
			Decedent's Name	(First, Middle,	Last)								2. Date of De	ath			3. Time of Death
	Physici /Medic		Mary Jar	ne Wal	sh								Month Januar	Da V	16, 20	^{rear} 205	1:15 p M
	Examin		4a. Facility Name (If r	not institution,	give street and n	umber)			4b. City	Town, or L	ocation	of Death			c. County of		
			1609 Ster	n Ct.						Anna					Anne	Aru	ndel
	Funeral		5. Social Security Nur		6. Sex 1 □ M 212 F			t birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	Date of Bir (Month, Da	y, Year)	9. Birthp Coun	lace (Stete or Foreign try)
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	land ow			10b. County		1	10c. City,	Town or Lo	cation				1			1	0d. Inside City Limits
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	r 28s	Director	10e. Street and Numb	ber					10f. Zi	Code				10g. C	itizen of Wh	at Coun	try?
	th wit		1609 Ster	n Ct.						21	401				τ	JSA	
	ems ems	Funerai	11. Marital Status		12. Was De Armed I		er in U.S.	13. \	Was Dece	dent of His	panic Or	igin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Black	Americ White,	
36	or it		1 Never Married		If Yes, C	2 ⊠ No Give	•	i	1 ☐ Yes		Specify:				Specify:		
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au	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or items 23s or 28s-f show marked other than "natural; or lems 12s or 28s-f show matte event; the Medical Examiner must be notified at	To B	Thomas N	Morris						E	Cile	en Sh	anahan				
Maryland 21215-0036	A DE E		19a. Informant's Nan	ne/Relationsh	ip (Type, Print)			19b. Mailir	ng Addres	s (Street ar	nd Numbi	er or Rura	Route Numb	er, City	or Town, St	tate, Zip	Code)
	1 and 2 Health a tem 27 is		John Wal	lsh/Hus	band			1609	9 Ste	rn Co	ourt,	Ann	apolis,	. MD	214	01	
ore.	of Hear fitern		20a. Method of Dispo		3 Removal from	m State	сел	ce of Dispo	natory or	other place,			. 21,		ocation - C		
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Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Fund	eral Service L	icensee			Ba	Name a	nd Address ICO &	of Facili Sons	by P.	A. Seve	erna	Park	Fun	eral Home
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	edicai	29a. Certifier 1 (Check only 2 one)	Medical E	Physician: To to eminer: On the and ma	he best of a basis of ea anner state	xaminatio	edge, death n and/or inv	occurred vestigation	at the time n, in my opi	, date an nion, dea	nd place, a oth occurre	and due to the ed at the time,	cause(s date an	s) and mann id place, and	er as sta d due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and ti	itle of certifier	N	OL	De-0	u ty	<i>g</i>	c. License					ate signed (Month, L	Day, Year)
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			30. Name and address	ss of person w	no completed co	use of dea	ath (Item 2	3a) (Type,	Print)		- 1	1			15 0		
			Willi	Am	P. 5	ont	25)	mD		295	X	me	erici	4	Ct	- 0	21035
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Physic	ian	1. Decedent's Name (First, Middle	le, Last)		-			2. Date of D Month	eath Day	Year	3. Time of Death 2: 28A	
/Medi	cal	Lawrence 4a. Facility Name (If not institution		···mbocl			or Location of Dea	Januar		2005 y of Death	2. 4073	<i>n</i>
Examir	ner	Union Memori				Balti		I(I)	40. 00011	y or Doain		
Funeral Director		5. Social Security Number 220–22–5895	6. Sex 1 X M 2 ☐ F		s. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hr	s. 8. Date of B (Month, D	ay, Year)	9. Birthplac	ce (State or Foreig y) NC	חק
**		Usual Residence of Decedent						00 1				
anylan show		10a. State 10b. County		10c. C	City, Town or Lo					10d	d. Inside City Limit XX es 2 □ N	
Sa-1 of	Director		JA		Balti				10g. Citizen of	14/5 - 1 00 1		_
with t	D	10e. Street and Number	acat Dr	i		10f. Zip Code 212	15			J.S.A.	•	
death with the Maryland me 23ar or 28a-1 ehow rinner to indified at	Funeral	4239 St. Vir	12. Was De	cedent Ever in	U.S. 13.		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N		ce - American	n Indian,	
INTE, MATYICALD ZIZID-UUSO 8 1 s.d.2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23st or 28s-1 show other traumatic event, the Moulcal Exprinterioual to incline at	by Fun	1 Never Married 2 Mar	If Yes. C	: 2 ⊡*N o Bive		f Yes, specify Cu 1 ☐ Yes 2 🔀 No		rto Rican, etc.)	Specia	ack, White, etc. $B1$ a	ack	
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Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State M	-		ry Inc.	2/1/05	Balt	imore	, Md	
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death certifi death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live	birth 2 Fe	tal death 3	Ectopic pregnant Other (specify)	су				ay Year	
the d	hysi	9 Unknown	9□ Unk	nown				-				
ords, P.O. BOX or requires that the death certification signed by the attending hould be detached for use a	þ	Part II. Other significent condition Diabetes Melli	_	death but not re	esulting in the u	nderlying cause (given in Part I.	1	Tobacco use con		cause of death?	'n
2 2 0	Completed							24a. Wa	s an 24b.	Were autops	sy findings availab pletion of cause of	le
The lav	omp		- 21					aut per 1 🗆 Yes	formed?	death? _	pletion of cause of No	
VICIAN: The sician: The certificate rector, pag	0	25. Was case referred to medica	al				26. Place of D	eath (Check only		1 103 2	2110	
Of VITA Physician: this certific ral director,	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	ther: 4 🗌 Nursing	Home 5 ☐ Re	sidence 6 🗆 Ot	her (Specify)		
E 6 € 8		27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	/8.40	e of Injury onth, Day Year)	28b. Time o Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how injury occu	rred		
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medice	ing Physician: To the Examiner: On the and ma	he best of my k basis of exami anner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and pla- opinion, death oc-	ce, and due to th curred at the time	e cause(s) and m e, date and place,	anner as stat , and due to ti	led. he cause(s)	
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,		+ Asan	romin	, N	11)	AT	2438	746	January	127,	2005	
k		30. Name and address of person	n who completed ca	use of death (It	em 23a) (Type,	Prinion N	lemorial i	Hospital	201 East Baltima	University MD	ty Pkwy 21218	
St. Regist	ate rar	31. Date filed (Month, Day, Year	2005	Registrar's Sig	nature A	College of				7		

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 1 **Physician** 5 FEB 2005 3:30P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES MARINER HEALTH CARE LAUREL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. M 2□F Yrs. MD Director 425.64.1824 70 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director PRINCE GEORGES LAUREL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 14200 LAUREL PARK DR 20707 death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. typy es 2 □ No If yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No XX Specify: <u>۾</u> 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the process of the 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 Is marked other 11 any injury or other traumatic event, III.s once. BUSINESS OWNER PIANO & MOVING CO. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY BANKS ROOSEVELT ANDREWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6913 MAYFAIR RD LAUREL, MD 20707 SYLVIA ANDREWS 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition LIBERTY BAPTIST CEM Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) LIBERTY, MS unk 22. Name and Address of Facility FINK FUNERAL HOME, P.A. uneral Service Licen GREGORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 23a. Part I. Enter the disease or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a Insequence of): neum Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as Division of Vital Records, P.O. Box 68760, Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 20 No 1□ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, 20 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident i Director: d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Dev. Year) leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come E. PASHAM 201 0 31. Date filed (Month, Day, Year) 32. Regismer's Signature State Registrar

Dhari		1 - State Amend Item 5 1. Decedent's Name (First, Middle, Las	t)				-	2. Date of Month	Death	ay Ye	3: Time of Death	
Physici /Medio		<u>M</u>	MARY L. BAILEY					Febr	uary	2,200	5 6:30 PM	
Examir	ner	4a. Facility Name (If not institution, give					Location of D	eath	4	c. County of D	eath	
E		5T. AGNES HEALT 5. 2145-16-3304 6. Se		ast birthday)			nore If Under 24	Hrs. 8. Date of	Birth	9.	Birthplace (State or Foreig	
Funeral Director		220 - 36 - 24/12 1	⊐м 27Д ғ 86	Yrs.	Months	Days		Min. (Month, 3–6–	Day, Yea.	r)	Country) MD	
how		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limit	
SI-88	ctor	MD	I/A	BALT	IMORE				-,		XXYes 2□N	
men. The most case of the man	Funeral Director	10e. Street and Number 701 N. ARLINGTON	AVENUE		10f. Zip 0	21217	7		10g. C	USA	Country?	
ema (ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decede	nt of His	panic Origin , Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - A Black, W	merican Indian,	
arment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 8.	þ	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2		Specify:	,		Specify:BI		
netur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usuai kind of work	done du	uring most of	working	16b.	Kind of Busine	ss/Industry	
han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	MAID	DO NOT use	retired)	3		HE.	ALTH		
ital Hygie id other t event, to		17. Father's Name (First, Middle, Last)		TEXTE			18. Mother's	Name (First, Midd				
Mental larked of	To Be	HARRY PARKER						E V. BEA				
Ith and Men 27 Is marke r traumatic		19a. Informant's Name/Relationship (7 JACQUELINE MYLES)	уре, Print) 'SISTER	19b. Mailir 30	ng Address (1 MCMI	Street ar ECHEI	nd Number o N ST.,	BALTO.,	MD City	or Town, Stat	e, Zip Code)	
f Hea Item othe	1	20a. Method of Disposition	CO.	ace of Dispo	sition (Name	of ner place	, 1	Date	20c. l	Location - City	or Town, State	
nt: If ry or		18 Seurial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) A-butus 2-07-05 Batta										
Department of I Important: If Ite any injury or of once.		21. Signature of Funeral Service Licens		22	. Name and		of Facility		MOR	TON & S	SONS F.H, INC	
price	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Litable of high that initiated events resulting in death) Last	a	ence of):							Nine day.	
igned by the attending phys be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of dea 9□Unknown	death 3	Ectopic pre					23d. Date of Month	delivery Day Year	
signed b	by	Part II. Other significant conditions of HYPERTENSI		lting in the ur	nderlying cal	ise giver	n in Part I.				o to the cause of death? Probably 4 Unknown	
s peen s	lete	DIABETES						24a. W	as an	24b. Were	autopsy findings available	
page 2	Completed	HEART DIS	FASE					— au pe 1 Yes	lopsy formed? 2 X N	death		
certificate rector, pag	Bec	25. Was case referred to medical examiner?	C7() C				26. Place of	Death (Check onl	- ` `			
	70	1 Yes 2 No	Hospital: 1 X Inpatient 2 ☐ E	R/Outpatien			4 LINUISII	g Home 5 □ Re	sidence	6 □Other (S	pecify)	
h. After this funeral di	inol	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28: M	c. Injury a		28d. Describ	e how inju	ury occurred		
er death rector: , by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	eet, factory,		es 2⊡No		(Street a		Rural Route Number,			
rs aft ral DI led in			building, etc. (Specify)									
within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ace, and due to the courred at the time	e cause(s e, date ar	s) and manner nd place, and c	as stated. due to the cause(s)						
£ 1 E	Σ	29b. Signature and title of certifier		29d. D	ate signed (Mo	onth, Day, Year)						
≱ ⊢ ŏ		n 1	-		0.4	7./	- 60		6.1		-	
r 8		Bahru, M3 30. Name and address of person who of Menbere Bahru, ST 31. Date filed (Monte Day Year) 7	<i>)</i>			16	0 1		100	ruary	2,2005	

State of Maryland / Department of Health and Mental Hygiene, 03406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BRINKMAN PEBUARY Day HENRY **Physician** AUL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANDALISTOWN 3 ALTIMORE HOJPITAL NONTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 14, 1916 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-07-0429 88 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 27 is marked other than "netural", or items 23a or 28e-f ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Howard Ellicott City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 Hickory Mede Drive 21042 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 기 전 Yes 2 Do If Yes, Give Year or Dates: Peacetime 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chief Executive Officer Contracting Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe eny injury or other treument. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brinkman Sara Alvin Gustav Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10903 Kriserin Circle, Chester, Virginia 23831 Paul H. Brinkman Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/05 Baltimore, Maryland Loudon Park Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Ligensee Jam J. Chriaty 3620 Wilkens Ave., Baltimore, MD 21229 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUL PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by AILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 21**200**0 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 Yes After the funeral 27. Manner of Death 1 Deathatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 77333 PEDRYARY 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NHC, 21133 RAVI 1 ALTO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Glown & Sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20 State of Manyland Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** FEB TOSHUA BAZEDORE 11.30 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE FUTURE CARE IRVINGTON (117 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F NORTH CAROLINA Director 03/31/1933 215-28-6602 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director MD N/A BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 501 DOLPHIN ST, APT. 503 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HARBISON-WALKER Elementary/Secondary (0-12) 12TH College (1-4or 5+) LABORER REFRACTORIES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental h JEFFERSON BAZEMORE **ESTHER** (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 801 WINTERS LANE, APT 439, CATONSVILLE, 19a. Informant's Name/Relationship (Type, Print) Health ELLA BAZEMORE/WIFE permit. Pages 1 an Department of Heali Importent: If Item 2 any injury or other t 20c. Location - City or Town, State Randallstown Md BALTIMORE CO. 20b. Place of Disposition (Name of Kingme Mentor Parks)
ARBUTUS MEM. PK. 2-12-05 20a. Method of Disposition V☐8urial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 P I A-Er er that a sase, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, / r hear ailure. List only one cause on each list. 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD Approximate Interval Between Onset and Death Immed at Cause (Final disease or condition METABOLIC ENCEPHALOPATHT **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLICILLS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit INSUFFICIENCY Due to (or as a consequence of): HTPERTEN SION attending physician pe Physician/Medical the use as l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached o 9 Unknown signed by I Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospitel or Attent within 24 hours after death To the Funerel Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING DOD 56948 2005 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DELPHN STREET BALTIMINE TANSINDA AMES 522 2005 Registra's Signature 31. Date filed (Month, Day Year) 0 State Registrar

				State of Mandan				_	_	
			For State	State of Marylan		rtificate of			71115	031.08
			Registrer 1. Decedent's Name (First, Middle, Last)		Cei	lilicate of	Dealli	2. Date of Deal	eg. 140.	3. Time of Death
	Physicia	an		BASK	FRVI	LIK		Month FEBRUA	Pay Year	non A
	/Medic	al	4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Dea		4c. County of De	
	Examin	er	NORTHWEST HOSP		N.		LLSTON		BALT	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hr			irthplace (State or Foreign Country)
	Director		214-40-1446	м X IXF 65	Yrs.	Months Days	Hours Mir	8. Date of Birth (Month, Day, 04 02	39	VA
b	>		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ocation				10d. Inside City Limits
laryla	shor	٦				sville				1 ☐ Yes 2 No
the N	28a-1	Director	MD Baltimo	re	PIKE	10f. Zip Code		1	0g. Citizen of What 0	Country?
with	la or		5 Courtland Woo	des Circle			1208		U.S.A	
death	ms 20	Funerai		2. Was Decedent Ever in U.	S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Am	encan Indian,
after	or Item	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2∑ No 1f Yes, Give		ir Yes, speciny Cuba 1 □ Yes XX No	specify:	no rican, etc.)	Black, Wh	
U Z I Z I 3-UU30 filed within 72 hours after death with the Maryland	ral',	d by	3 X Widowed 4 □ Divorced	Year or Dates:				F3:		Black
72 h	natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of we	orking	16b. Kind of Busines	s/Industry
Agbin A	than w	mp	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+) na		amstres	,		Denartme	nt Store
7 pe	Hygiene. other than ent, the N		17. Father's Name (First, Middle, Last)	II d	, DC	amb CI CB		me (First, Middle, I		ne beore
d be	Mental arked o	To Be	George Newson				Katie	Catler		
should be	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, the Modical Examiner; and be notified at	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Number	City or Town, State,	Zip Code) 21208
and 2	m 27 ls		Karen Clark-Dau	ghter	5 Co	urtland	Woods	Circle,	Pikesvi	
	Department of Heall Important: If Item 2 any injury or other 20058.		20a. Method of Disposition	20b. P	lace of Dispo emetery, crei	nsition (Name of matory or other plac	ce)	Date	20c. Location - City o	r Town, State
Page	ant: If		' 4 ☐ Donation 5 ☐ Other (Specify)	Kiı	ng Me	morial :	Park 2/	/8/05	Randalls	town, Md
Dallimor	Departr Imports any inju		21. Signature of Funeral Service License	· // O ,	M ²	arch F/	ss of Facility H West			
<u> </u>	TQ E # 8		1) mile	K pres	4	300 Wab	ash Ave		more, Ma	
			23a. Part1. Enter the disease, or complice shock, or he in failure. List only on	ations It At caused the death e caus on each line.	n. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)		7515					
	Medical xaminer		resulting in death)	Due to (or as a consequ		D WIA				
		-	Sequentially list conditions, b.	Due to (or as a consequ		DNA				
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate bases. Ent. of January Cause (Disease or injury	4.7	MEN	TIA]
ou, be executed	n and lal-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequ		1				
rou,	ysician and ie burial-transit	cal	d							
ords, P.O. Box 687	been signed by the attending phys should be detached for use as the	ledi	AC ECHALC.							
DOX	tendir r use	an/\	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
De dea	he at ned fo	Physician/Medi	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)				32)
r tag	d by Jetach	Phy	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ndertving cause giv	en in Part I.	23e. Did tot	acco use contribute	to the cause of death?
LS,	signe d be d	l by	Takin. Other argitimean continues con			,g cacco g		1 □ Ye	s 2 No 3 F	Probably 4 Onknown
	peen	ompieted				.,		24a. Was a	n 24b Were a	autopsy findings available
The law	has ge 2	mp						autops perform	y prior to ned? death?	completion of cause of
	ificate or, pa	e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 eath (Check only on		s 2 No
01	s cert	o Be	examiner?	ospital: Inpatient 2	ER/Outpatier	nt 3 DOA Oth	or	The state of the s	ence 6 □Other(Sp	ecify)
0 9	er this	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe ho	w injury occurred	
	ath. r: Afti ie fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(North, Day 18al)	injury		Yes 2 □ No			
DIVISION I or Attending	recto by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, sti	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
בֿ בֿ	rs aft ral Di									
Hoen	Fune Fune tely fi	edicai	(Check only 2 Medical Exemin	ician: To the best of my kno her: On the basis of examina	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
adt	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	29b. Signatura and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
Ļ	≥ ± 8		I WILL OF	L MD	,	D	53910		-7€B 4.	2005
	n		30. Name and address of person who co	maleted source of death (Item	232) /Тура	Print)			ebruary	
			A. MAHESUWARI	MP. NORTH	WEST	HOSPITA	AL, RA	NDALLST	DWN, M	D
	Sta	te	A. MAHESINGEL 31. Date filed (Month, Day, Year) FEB 0 7 2	32. Regultrar's Signa	ture	Annelle &				

8

					Department of Health and M	-	•	
			1_ State	•	Certificate of Death	Reg.	0000	00100
			Registrar 1. Decedent's Name (First, Middle, Last)		John Marie Of Board	2. Date of Death	No. Z	3. Time of Death %
	Physici		Wilma Maxine	Beck		Februa	Day Year	7 1:05 M
	/Medic Examin		4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Location of Death	7	4c. County of Deal	
			North Arundel Hospital		Glen Burnie		Anne Ar	undel
	Funeral		5. Social Security Number 6. Sex 7.	. Age (In yrs. last birti	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birt Co	hplace (State or Foreign untry)
ı.	Director		379-24-2246 Usual Residence of Decedent	77	frs.	Aug. 6,	1927 M	ichigan
	land ow		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Mary Fred	tor	Maryland Anne Arundel		Severn			1 ☐ Yes 2 📆 No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	th wit		7808 Grandison Way		21144		United S	tates
	r dea	Funerai	Armed Forc		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
20	hours after tural', or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give- 3 ☑ Widowed 4 ☐ Divorced Year or Date	X No	1 ☐ Yes 2√☐ No Specify:		Specify:	White
	hour		15. Decedent's Education	16a. [Decedent's Usual Occupation	16b	. Kind of Business/	
<u>ლ</u>	within 72 ene. than "na	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)		(Give kind of work done during most of working life. DO NOT use retired)	ng		,
7	be filed within 72 hours after death with the Marylan dal Hygiene. dat Hygiene. dat Hygiene. death, it is madical Examinational be multiped at avent, it is Madical examinational be multiped at	Completed	2 yr		Homemaker/ Teacher		Own Hom	e/ Piano
and	be filed vital Hygie d other i	Be (17. Father's Name (First, Middle, Last)			(First, Middle, Maid	den Sumame)	
>	should I	70	Homer Chips Pettijo		Effie	Mae Re		
Z Z	S1 50 72 60		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Number or Rura			
	s 1 and if Health item 27 other to		Barbara Lynn Wickline/dau			York Spri	Inys, Pen Location City or	nsylvania Town, State
٥	90 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St.	cemetery	v, crematory or other place) cundel Crematory 2/7/		lenton, M	
altimore,	C .		* 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licensee	west m	T			
ñ	Depa Impo any is		Juanta R Thomas	M00957	22 Name and Address of Facility Donaldson Funeral H 1411 Annapolis Road			
			23a. Parth Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	used the death. Do no	ot enter the mode of dying, such as cardiac o	r respiratory arrest,	i snar y ran	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	P	nomi a			Onset and Peath
	/Medical		resulting in death)	r as a consequence of				1 1495
	Examiner	_	Sequentially list conditions, b.		Δ.			
٦	pe jist	Examiner	cause. Enter Underlying	r as a consequence of	ry:			
	be executed ician and burial-transit	xar	that initiated events c.	r as a consequence of	f):			
20	ate be executed hysician and he burial-transit	cail	d					
9	certificat Iding phy Ise as the	edi						
Ŏ	th cer lendir r use	an/h	23b. Was decedent pregnant	ome of pregnancy	3 Ectopic pregnancy		23d. Date of deli	′
	e death the atter	Physician/M	in the past 12 mopris? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nt at time of death vn	5 Other (specify)		Month	Day Year
Ţ.	that the death certifica ed by the attending ph detached for use as th	Phy	Part II. Dther significant conditions contributing to deal	th but not resulting in	the underlying cause given in Part I.	23e, Did tobaco	o use contribute to	the cause of death?
as,	es be	d by	Chironic ativ	e Lib	rillation	1 Tes	2 → No 3 → Pro	bably 4 Dunknown
ecoras	> 970	iete	5212 112	di sorof	2.4	24a. Was an	24b. Were au	topsy findings available
T,	0 5 0	Completed				autopsy performed	prior to o	ompletion of cause of
	ician: The certificate rector, pag	a	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 2 ☐ (Check only one)	10 103	20,140
	ys is	To B	examiner? 1 Yes 2 No Hospital: 1 Inp	patient 2 ER/Outp	patient 3 DOA Other: 4 Nursing Hon	ne 5 Residence	6 ☐Other (Spec	ify)
10 0	ding Ph h. After th funeral		27. Manner leath 28a. Date of (Month,		me of 28c. Injury at 2 jury Work?	8d. Describe how in		
VISION	tendi death. tor: A the fu	cati	2 Accident investigation		M 1 Yes 2 No	Of Location (Carret	and Mumber of Bu	-18-11
\geq	or At after of Direct in by	Certification:	determined 286. Place of	ninjury - At nome, tarr g, etc. <i>(Specify)</i>	m, street, factory, office	8f. Location (Street City or Town, St		rai Houte Number,
_	spital		29a. Certifier 1 Certifying Physicien: To the bo	est of my knowledge,	death occurred at the time, date and place, a	nd due to the cause	(s) and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	(Check only 2 Medicel Exeminer: On the basione)	is of examination and	/or investigation, in my opinion, death occurre	d at the time, date a	and place, and due	to the cause(s)
	To the within to the comp	ž	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month	, Day, Year)
			I had I lulew	5	D24985	J-	ze Gruar	4 5 2005
	1.		30. Name and address of person who completed cause	of death (Item 23a) (T	Type, Print) Charles E.	W.165	M.D	1
	V	10	31. Date filed (Month, Day, Year) 32 Reg	gistrar's Signature	spitur Glend	ornie	MJ	-
	Sta Registr		FFB 0 7 2005	gistrar's Signature	grante			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#1, perMD C840.2/7/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Pamela Jean Bishop 2. Date of Death Day Month Year **Physician** PAMEVA 10:15 AM 31 2005 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY BALT MULE C., 1

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Feb. 13, 19 THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign
Country) Months 1 □ M 2 💢 F 308-82-7864 Yrs. 1963 Virginia Director 41 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event. The Medical Exal, and must be excitived at Director 1X☐Yes 2 ☐ No Maryland Prince Georges Bowie the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 13052 Marquette Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic 2005. Elementary/Secondary (0-12) College (1-4or 5+) 5 Electronics File Specialist IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) C. James Bishop Jean Van Unen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Bishop/ Sister 2632 Springfield Avenue Ft. Wayne, IN 46805 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 02/03/2005 Waldorf, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home LA P. Kan 16000 Annapolis Road Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK 24 hours /Medical Due to (or as a consequence of) **Examiner** EXTENSIVE INTENABDOMINAL CANCER 5 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical as the IF FEMALE. use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No P.0. detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 99 LYSIS SYNDROME 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 has autopsy performed? certificate 2□No 1 X Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 JANUARY 31, 2005

DHMH 17 Rev 1/2001

State

Registrar

10

30. Name and address

31. Date filed (Month, Day, Year)

AHONKHAI

FEB 0 7 2005

AIMA

marke

600 NOKTH WOLFE STREET BALTIMORE, MARYLAND

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H			ene 200	5 03411
ı	Physici		1. Decedent's Name (First, Middle Arthur Brad					2. Date of Death Month O I	2 ⁵ 2ďő!	3. Time of Death 5 4:35 A M
	/Medic Examin		4a. Facility Name (If not institution			4b. Cîty, Town, or Silver			4c. County of Dea	
	Funeral Director		5. Social Security Number 240-72-1946	6. Sex 7. Ago 12 M 2 □ F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^(ear) 1946	rthplace (State or Foreign country)
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State unk 10b. County	unk	10c. City, Town or Lo	ocation			unk	10d. Inside City Limits unk¹□Yes 2□No
	3e or 28	i Director	10e. Street and Number		un	.k 10f. Zip Code		unk 10g	p. Citizen of What C USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic avent, the Medical Exam and must be indiffical at ODGe.	by Funeral	11. Marital Status Un 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces?	vo unk	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
Maryland 21215-0036	within 72 hou ene. than "neture	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) unk	's Education It grade completed) College (1-4or 5	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	during most of wo	rking unk 16	b. Kind of Business	
/land 2	uld be filed Mental Hygid srked other atic avent, I	To Be Co	17. Father's Name (First, Middle,			unk	18. Mother's Na	me (First, Middle, Ma	iden Sumame)	unk
Man	nd 2 sho aith and I 27 is mu r trauma		19a. Informant's Name/Relations Holy Cross Hosp					ural Route Number, C Silver S		
Baltimore,	Pages 1 ar nent of Hea ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	oecify) in state	20b. Place of Dispo cemetery, crei			_	c. Location - City o	
Balt	permit. Departr Importa any inj		21. Sig atur Funera Service ROTALD	d 655 W. 1	3altimore	Street				
10	Prrysician /Medical		23a. Part Enter the disease, or shock or heart failure. List immediate Cause (Final disease or condition resulting in death)	a	sepsis	er the mode of dying	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death Days
	Examiner			b	a consequence of): Pneumonia	a, aspir	ation			Days
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
۵.	w requires that been signed b should be deta	by	Part II. Other significant condition Acute re	ns contributing to death b	=	nderlying cause give	en in Part I.			o the cause of death?
Il Records,		Completed	Stroke					24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vital	yaician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	ent 2 ER/Outpatier	nt 3□ DOA Othe		ath (Check only one) Home 5 - Residence	e 6 □Other /Sne	acity)
Division of	Jing Ph J. After th funeral		27. Manner of Death 1 Xelatural 5 Pendin 2 Accident investig	28a. Date of Injur (Month, Day ation	ry 28b. Time of	f 28c. Injury Work	at	28d. Describe how		sury)
Divis	i gitte	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	et and Number or F State)	ural Route Number,		
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the causured at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
L.	To the within 2 To the complete	Ž	29b. Signature and title of certifier	e in		29c. License			. Date signed (Mon	
,			30. Name and address of person		eath (Item 23a) (Type,	D-32	2332	0	01/25/20	Ub
			Suresh K. Gup	ta, 9801 G	Georgia A	ve, Sui	te 220,	Silver	Spring,	MD 20902
	Sta Registi		FEB 0 7 20	05 Alexandra	ar's Signature	r e				

			Please	State of Ma					•	•	jibie.	
	-		For State Registrar	State of Ma	ii ytai ii		tificate of		*	Reg. No."	05	03412
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		IDA BI	RANSKY					FEBRUA	Ry 02	2005	. 2.40AM
	Examin		4a. Facility Name (If not institution, giv		1		4b. City, Town, o	r Location of Dea		4c. Cour	nty of Death	h
			NOTETHWES			ALJ	RANI	SHYPE	TOWN			LORE.
	Funeral Director		5. Social Security Number 6. S 214-14-7172	Sex 7. Age I□M 21√2 F	(In yrs. I	as <i>t birthday)</i> 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h ''1 ^Y 9 ^{ar)} 7	9. Birth	hplace (State or Foreign untry)
			Usual Residence of Decedent			,			AI K.O,	,1507		141
	arylan show		10a. State 10b. County		10c. City	, Town or Lo						10d. Inside City Limits
	88a-f	Funeral Director		N/A		BAL	rimore					1 X Yes 2 No
	with t	ā	10e. Street and Number 3601 FORDS LAN	= #201			10f. Zip Code	21215		10g. Citizen o	of What Co	USA
	ms 23	era	11. Marital Status	12. Was Decedent I	ver in U.	S. 13.	Was Decedent of H 1 Yes, specify Cuba		Specify Yes or No-	14. F		rican Indian,
9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 A	ю		1 Yes, specify Cuba 1 □ Yes 2【X No	an, Mexican, Pue Specify:	rto Rican, etc.)		Black, White	e, etc. WHITE
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show ta Majical Exercities must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:						Spe		
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212	withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	SALI		~		RETAI	L	
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ylaı	should be ind Mental marked o umatic ave	70	ROBERT			PERI	_IS	BELLE				BRAUN
Maryland	2 sh and la m	77. 7	19a. Informant's Name/Relationship (**	- D		g Address (Street					
	1 and Health em 27 thar t		ROBERTA RABINE 20a. Method of Disposition	<pre>< / DAUGHTI</pre>	20b. P	ace of Dispo	B OLD PIM sition (Name of	1	Date	IMORE,		
nor	Pages nent of I int: If It		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		C	emetery, crer	natory`or other place _OM_CEMET		14/2005		•	RE, MD
Baltimore,	그 든 본 등		21. Signature of uneral Service Ce		JOIL		. Name and Addre		SOL LEVIN			
m	permi Depar Impo any ir		Whatau ?	Jugar		1	3900 REIS					MD 21208
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plic kong hat caused on cause on each lin	the death							Approximate Interval Between
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		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ		BITUS					
V	tuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nyury) that initiated events	C								
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9 x	certific iding p	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ncv				224 1	Date of deli	non.
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐Live birth 4 ☐ Pregnant at	2 🗌 Fetal	Ideath 3[Ectopic pregnancy Other (specify)	/			Month	Day Year
P.O.	t the c by the tacher	hys	9 Unknown	9□ Unknown								
	es tha igned be de	by P	Part II. Other significant conditions			_	nderlying cause giv	en in Part I.				the cause of death?
ord	requir	eted	CHRONIC AT	NAC 1-113R	JUA-	TION	<u> </u>		7		3 Pro	obably 4 Nunknown
Records,	e law has b je 2 sl	mple							24a. Was autop		b. Were au prior to c death?	topsy findings available completion of cause of
a		e Co	25. Was case referred to medical						1 Tyes	2 No	1 🗆 Yes	2 No
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Sior	andin eath, or: Af the fur	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n		,,		Yes 2 □ No				
Division of	or Att	Certification:	3 Suicide 6 Could not be determined		ry - At ho :. (Specif)	me, farm, str v)	eet, factory, office		28f. Location (S City or Tox		mber or Ru	ral Route Number,
П	Hospital or Attanding 44 hours after death, Funeral Diractor: After tely filled in by the funer	Ce	29a. Certifier 1 Certifying P	nysician: To the best	of my kno	wledge, deat	occurred at the tir	ne date and place	e, and due to the	cause(s) and	manner as	stated
	To the Hospital or Attanding P within 24 hours after death, To the Funeral Diractor: After t completely filled in by the funera	Medical		miner: On the basis of and manner sta	examina							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11-			29c. Licens			29d. Date sig		
•			Dadinger 1 2	nealta m.	0			1410		1-enris	ry o	2hol, 2005.
	2		30. Name and address of person who					NOER P				
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ture	- STHOME	Town m	10 211	5'5 4		
	Registi		31. Date filed (Month, Day, Year) FEB 0 7	2005	2500	H.	greete					
-												

			For State	State of Mary	land / Dep	artment of	Health and	Mental Hygie		. 00/1
3	,		Registrer 1. Decedent's Name (First, Middle, L		Ce	rtificate o	t Death	Reg.	No UUU	0341
	Physic	ian	Tarre					2. Date of Death Month	Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, gi	NTAFIO		4h City Tay	1	JANUARY "	27,2005	3.50
	Examir	ier		STHOSP	ITAI		or Location of Deat		4c. County of Death	
	Funeral			Sex 7. Age (In	yrs. last birthday	RANJ If Under 1 Yea		8. Date of Birth	15011	MOTE
ı	Director		207-01-9471	1☑M 2□F 85	Yrs.	Months Day		(Month, Day, Ye	ar) Cou	place (State or Foreign intry) PA
	pu ,		Usual Residence of Decedent					Jan. 28,	1919	
	aryla ehov	-	10a. State 10b. County	100	. City, Town or Le	ocation				10d. Inside City Limits
	he M	Funeral Director	MD Baltimor	re Ca	tonsvil]	Le				1 ☐ Yes 2☐No
	with t	금	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
	s 23	sral	801 Winters Lane			21228			USA	
	ter d	-un	11. Marital Status 1 □ Never Married 25€Married	12. Was Decedent Ever Armed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Btack, White,	
986	urs af	by	3 Widowed 4 Divorced	1√ Yes 2 No 1 If Yes, Give Year or Dates:	346	1 ☐ Yes 2√☐ No	Specify:whit	:e	Specify: whi	ite
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow Acal Examinat i ust by malified at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occi	Ination	16h	. Kind of Business/In	
218	within 7 ene. then "n	ple	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) Cotlege (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of wor ed)	king	Tand or Dusinessynt	
7	od wil	Son	12		Machan	ist		Wes	stinghouse	<u> </u>
nd	be file	Be (17. Father's Name (First, Middle, Las	1)			18. Mother's Nan	ne (First, Middle, Maid	en Sumame)	
yla	should to and Ment marked umatic o	2	Antonio Cantafio				Mame Mo	rell		
Maryland	2 sh and is m		19a. Informant's Name/Relationship					ral Route Number, City		
	l and lealth im 27 her tr	1 8	Anthony Cantafio-				errace Arb	utus, Mary	land 2122	.7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinations to the retified at once.		20a. Method of Disposition **Burial 2 Cremation 3	Removal from State		matory or other pla	· 1		Location - City or To	
틒	it. Partiment		' 4 ☐ Donation 5 ☐ Other (Special Signatur of Funeral Service L	(Y) Le	oudon Pa	rk Cemet	ery Jan.	31, 2005 B	altimore,	MD
Ba	permit. Departr Importe any inj		21. Signatur Pulteral Service Lis	h lana.	22	2. Name and Addr	ess of FacilityLou	don Park F	uneral Ho	me
			23a, Part1, Enter the disease, or com	polications that gauged the d	eath Do not ent	6ZU W1.1k	ens Ave.	Baltimore,	Maryland	
	e de la constante		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each tine.	oun. Do not on	er the mode of dy	ing, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	SEPSIS					
	Examiner			Due to (or as a con-	Maria Santa	- 0				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Et al. Underlying Cause (Disease or injury	b. Due to (or as a cons	sequence of):	E RENA	L FAIL	SKE		
	cuted nd ransit	Examiner	triat initiated events	C.						
Ö,	e exe ian ai urial-t		resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the buriat-transit	Ilcal		d						
9 xo	attending p	Physician/Medi	tF FEMALE:	220 Mars and and		The second secon				
Bo	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome of pre	etal death 3	Ectopic pregnanc	ÿ	1	23d. Date of delive Month	ory Day Year
o.	res that the de signed by the a be detached f	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at time o 9☐Unknown	ordeath 5	Other (specify) _				Day Tear
0	that	by Pr	Part II. Other significant conditions of	contributing to death but not	resulting in the un	nderlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Vital Records,	quire; in sign	q pe						1 🗌 Yes :		ably 4 MUnknown
000	s been si	olete						24a. Was an		osy findings available
Ĭ	The law cate has page 2	Completed						autopsy performed?	prior to con death?	npletion of cause of
<u> </u>	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	1 Yes 2 N h (Check only one)	lo 1 Yes	21 X No
ot <	d is	2	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	1 3□ DOA Oth		me 5 Residence	6 ☐Other (Specify	')
ב	ding Ph h. After th funeral	ou:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Da e of Injury (Month, Day Year,	28b. Time of Injury	28c. Inju	ry at	28d. Describe how inju		
<u>s</u>	tend Jeath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	9			Yes 2 □ No			
DIVISION	after after in by	ertification:	4 Homicide determined	28e. Place of Intury - Albuilding, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (Street a City or Town, Stat	nd Number or Rural le)	Route Number,
	spitel ours neral filled	O	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge death	negurad at the ti	ma data and land			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	edical	(Check only 2 Medicet Exen	niner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my	ppinion, death occur	and due to the cause(sed at the time, date ar	 and manner as stand place, and due to 	ited. the cause(s)
	To th within To th comp	¥ €	29b. Signature and title of certifier			29c. Licens	se number	29d. Da	ate signed (Month, D	Day, Year)
	V	1	> goginan	mella m	0	DYI	410	Jan	isin 27th,	2015
	10.1		30. Name and address of person who	completed cause of death (if	em 23a) (Type, F			NEHTH		
	V		MINTHWEST HIS	PITAL CENT	IL RA	HOAUS T	aMH W		5 .	
. .	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature					
	Registra		FEB 07	2005 Reserve	1 1/2	Coaste				

	1 - For State Registrar	State of Marylan				lental Hygie		5 03414
Physician /Medical	Decedent's Name (First, Middle, Last) HARRISON L. DAY					2. Date of Death Month	28 200	
Examiner Funeral	4a. Facility Name (If not institution, give s North Arunde 5. Social Security Number 6. Sex	Hospita 7. Age (In vrs.	ast birthday)	Glen If Under 1 Year	Burnie If Under 24 Hrs.	8. Date of Birth	Anne A	1 1
Director	216–18–5247 Usual Residence of Decedent 10a. State 10b. County	M 2□F 93	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 8-23-19	11 1	MARY LAND
ith the Marylan or 28e-f show e notified at	MD. ANNE ARUN		ERNA P	ARK				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
6 after death with the Mar or tlems 23a or 28e-f st direr must be notified funeral Director	872 BALTO. ANNAPO			10f. Zip Code 2114	46	109	. Citizen of What	t Country?
by [8] y	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? □ No If Yes, Give Year or Dates:	II	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	tispanic Origin? (Spe an, Mexican, Puerto i Specity:	cify Yes or No- Rican, etc.)		vmerican Indian, Vhite, etc. BLACK
121215-003 121215-003 99ien. "natural, it the Midical Exu.", it the Midical Exu."	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) -0-	(Give I life. E	ent's Usual Occup kind of work done O NOT use retired	during most of workii d)	ng	b. Kind of Busine	
for A A Manual Agiene. 2 should be filed within and Manual Hygiene. is marked other than eumetic event, the M. To Be Comp	17. Father's Name (First, Middle, Last) FRED STEPNEY				18. Mother's Name EMMA HAR	(First, Middle, Mai	iden Sumame)	
PAN SEIV NOTE, Mary ges 1 and 2 shoul ges 1 and 2 shoul ri li fine P21 is mari or other treument	19a. Informant's Name/Relationship (Type LILLIAN DAY (WIFE)				and Number or Rura NNAPOLIS B			e, Zip Code) RK, MD 21146
HHTRALSEN LYBBABBABBABBABBABBABBABBABBABBABBABBBBBB	20a. Method of Disposition 1	emoval from State CRO	VNSVILI 22.		ANS 2-3-2	005 CR	E & B SON	LE, MARYLAND IS MORTUARY, P
68760, tificate be executed was the burial-transit as the burial-transit edical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or a))).	Do not enter CON ence of): ence of):	r the mode of dyin				Approximate Interval Between Onset and Death
P.O. Box 6. nat the death certificate by the attending peterbed for use as Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 □£	ctopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
cords, P wrequires tha been signed Is should be det	Part II. Other significant conditions cont	ributing to death but not resu	ting in the und	derlying cause give	en in Part I.	23e. Did tobacc	5.4	to the cause of death? Probably 4 □Unknown
Vital Record elclen: The law requir certificate has been s frector, page 2 should						24a. Was an autopsy performed	prior t	
of Vita	TO THE ZEINO		R/Outpatient	3□ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hom	(Check only one) e 5 ☐ Residence	6 □Other (Sp	pecify)
rision Attending death. ctor: After y the funer fication	27. Manner of Death \[\frac{\hat{N}}{\text{Natural}} \] 20. Accident 3 \succeeded Suicide 4 \succeeded Homicide \] 4 Homicide The properties of the	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury ne, farm, stree		Yes 2□No	3d. Describe how in Bf. Location (Street City or Town, St	and Number or	Rural Route Number,
Div. To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my know or: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the tim stigation, in my op	e, date and place, ar pinion, death occurred	nd due to the cause of at the time, date a	e(s) and manner and place, and d	as stated. ue to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	mis		29c. License	number 3977	29d. 1	Date signed (Mo	nth, Day, Year)
State	30. Name and address of person who com M. J. L. L. L. L. L. L. L. L. L. L. L. L. L.	pleted cause of death (Item 30)	19776	Dews	e, Glon	Bumie	nis	2/06/.
Registrar DHMH 17 Rev 1/2001	FEB 0 7 20	05 <i>Jane</i> .	RIGINAL	bask				

			1 - For State Registrar		Sta	te of M	larylar		artmen <i>tificate</i>			and M	lental Hyg	jiene		5	03415
П	Physic	ian	1. Decedent's Name (First, Midd			•							2. Date of Dea Month	th		or	3. Time of Death
	/Medi	cal	Madeline I 4a. Fecility Name (If not institution)			and as some horse	1		4. 00				Feb.	Pay 4		5	12:15a ^M
1	Examir	ner	Lochraven Ce			na namoer,	,			alti	Location o	of Death			County of D		
П	Funeral		5. Social Security Number	6. Sex			ge (In yrs.	last birthday)	If Under Months	1 Year	If Under:	24 Hrs.	8. Date of Birth		altim		e ace (State or Foreign ry)
	Director		213-26-2355	1	M 2[_AF	81	Yrs.	Monus	Days	Hours	Min.	Month, Day	5,1	923	Ma	ryland
	/land		Usual Residence of Decedent 10a. State 10b. Count	y			10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
	Man e-fsh	tor	MD Carr	011			F	inksb	ura								1 ☐ Yes 🏋 🏋 No
	or 28	Director	10e. Street and Number						10f. Zip	Code			1	0g. Citi	zen of What	Count	ry?
	s 23e		2206 Cedar								2104				U.S		
10	riter d	Funeral	11. Marital Status 1 □ Never Married ※※ Ma		Arm	S Decedent led Forces? Yes VIV	?	.S. 13. V	Vas Decede Yes, speci	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		4. Race - A Black, W		
036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show after Examitter out the notified at	by	3 Widowed 4 Divorce		lf Yea	Yes XX es, Give ir or Dates:	110	1	☐ Yes 🔀	X No	Specify:				Specify:	Wh	ite
5-0	be filed within 72 ho tal Hygiene. d other then "naturesevent, I've Moorese	Completed	15. Decede (Specify only high	nt's Educ	cation	leted)		16a. Deced	ent's Usual kind of work	l Occupa	tion	of working	20	16b. Kii	nd of Busine	ss/Indi	ıstry
121	within ene.	dmo	Elementary/Secondary (0-12)		Coll	ege (1-4or	5+)	life. L	OO NOT use	e retired)		0. 1101111	,9				
d 2	e filed within al Hygiene. I other then vent, the Ma	Be Co	17. Father's Name (First, Middle	, Last)				Н	omem			r's Name	Own Home				
ılan	should be nd Mental marked c	To B	John Ogle										Vild		Jamame,		
Maryland 21215-0036	2 a a a		19a. Informant's Name/Relation	ship (Typ	oe, Prin	nt)		19b. Mailin	g Address	(Street a				r, City or Town, State, Zip Code)			
	s 1 and 3 if Health item 27 other tr		XXBurial 2 Cremation 3 Removal from State														
Baltimore,	Pages 1 nent of P int: If ite iry or ot												Location - City or Town, State				
Ē	permit. Pages Department of I Importent: If ite eny injury or of		' 4 □ Donation Other (1	_	Mar								wings	3 M:	ills,MD
Ba	permit. I Departm Importer eny injur		1 Trekan	1/	ur	we		Ec.	khard	t Fu	inera]	Cha	apel P.A		Milla	M	i. 21117
			23a. Part1. Enter the disease, or shock, or heart failure. Lis	r complic	ations	that caused	the death	Do not ente	r the mode	of dying	, such as c	ardiac or	respiratory arre	est,	HTTTO	1	Approximate
	Physician	1	Immediate Cause (Final disease or condition	, a			-2	NEUN	2021	A							nterval Between Onset and Death
	/Medical Examiner		resulting in death)		Du	ue to (or as				, ,						7 "	20 20(67)
		5	Sequentially list conditions,	b.	Dı	ue to (or as	a consequ	ience of/:								_	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Classes or highly that initiated events	<				201100 01).									
o O	an an urial-tr	Exa	resulting in death) Last	С.	Du	ue to (or as	a consequ	uence of):									
8760,	icate be executed physician and s the burial-transit	dlcal		d.	_												
9 ×	eath certific attending p	/Mec	IF FEMALE:	22	lo lf vo	a autaama								T		ļ	
Box	atten f for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23	1□ι	s, outcome Live birth Pregnant at	2 Fetal	death 3 □I	Ectopic pred Other (spec	gnancy				23	3d. Date of d Month	,	ay Year
0	that the de led by the a detached f	hysi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown			Jnknown		Julii 3 🗆	Other (Spec	July)							
S,	Se Pe	by P	Part II. Other significant conditi			to death b	ut not resu	ilting in the un	derlying cau	ıse giver	in Part I.		23e. Did tob	acco us	e contribute	to the	cause of death?
ord	w require been si should b	ted	DEME										1 □ Ye	3 2 □	No 3□1	Probab	ly 4 Unknown
Records,	has bu	Completed	ettronic er	STRE	107	105	PUL	MONA	ry	DIS	Ens	E	24a. Was an autopsy	.	24b. Were a	autops	y findings available letion of cause of
											<u>-</u>		perform	ed? X No	death? 1 ☐ Ye	· i	O'No
Vita	ysicien: is certific director.	o Be	25. Was case referred to medica examiner? ↑ □ Yes 2 ☒ No		spital:	1 🗌 Inpatie	-1 000			Other			(Check only one				
o l	g Phy er this neral c	H +	27. Manner of Death			Date of Injur Month, Day		ER/Outpatient 28b. Time of		. Injury a Work?	4 Nurs		e 5 Resider			ecify)	
30	Attending F death. ctor: After y the funer	atlo	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	gation	{	мопіп, Day	/ rear)	Injury	М		s 2 🗆 No						
DIVISION	of or Attend after death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. F	Place of Inju	ry - At hor (Specify)	me, farm, stre	et, factory, o	office		28	3f. Location (Stre City or Town,	et and State)	Number or F	Rural F	loute Number,
_			29a. Certifier 180 Certifvir	- Phusi								174					
	e Hospitel or 24 hours afte e Funerel Dir letely filled in	edical	(Check only 2 Medical one)	Examine	in Our	o the best of the basis of manner sta	examinati	vledge, death ion and/or inve	occurred at estigation, in	the time my opir	, date and nion, death	place, an occurred	nd due to the cau d at the time, dat	ise(s) a e and p	nd manner a lace, and du	as state ie to th	ed. e cause(s)
	4 5 4 4		29b. Signature and title of certifie	r .)			29c. l	_icense r	number		29	d. Date	signed (Mon	ith, Da	y, Year)
			1 7 bol	10	-	V	up		DO	006	176	55	FE	RUD	ny cl	it	2005
	1		30. Name and address of person				eath (Item	23а) (Туре, Р	rint)				2	()	-1-T		
	O		31. Date filed (Months Par Voor)			JOO Polistra	33	SO WI	CKENS	A	JE #	101	BALTIN	nor	EM	D	21229
	Stat Registra	e ir	31. Date filed (Month Pag Year)	7 200	05	32. egistra	So A	K A	وعليه								

			For State Registrar	State of Ma	aryland / Depa			lental Hyg	liene	5 03416
			1. Decedent's Name (First, Middle, Last,		^	Timouto o	, Death	2. Date of Dea	eg. Nó.⊸	3. Time of Death
	Physici		John Palmer	Ferrel	20			Month Fels	Day Ye	er no 0
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death		4c. County of D	
			Sinai Host	rifal		Ba	ltimore	•	N/A	
	Funeral		5. Social Security Number 6. Set 244-42-2351	7. Ag	e (In yrs. last birthday) 71 Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	261	/ 1 Yrs.			Aug. 22	2, 1933No	rth Carolina
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man e-f sh	į į	Maryland N/A		Baltimore	2				1≹Yes 2□No
	th the	lec	10e. Street and Number			10f. Zip Code	•	1	0g. Citizen of What	Country?
	23a usi b	by Funeral Director	5424 Nelson Ave			21215			USA	
	tems reference	nue		12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
36	s afte	Ϋ́	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give	10	1 ☐ Yes 2 🖾 N			Specify:	Black
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28e-f show ilsal Exament nutt be inclified at	edt	15. Decedent's Edu		16a. Dece	dent's Usual Occ	cupation		16b. Kind of Busine	ass/Industry
215	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5	(Give	kind of work dor DO NOT use reti	ne during most of work ired)	ing		
21	giene giene er the	Completed	12	00/10ge (17401 0		Army			U.S. Gov	ernment
pu	be file tal Hy d oth	To Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			. 1
<u>y</u>	Men Marke Marke	ပို	Leroy	Ferrel1			Elizab			che
Maryland	d 2 sh th and 7 Is n treun	15	19a. Informant's Name/Relationship (Ty				et and Number or Run			e, Zip Code)
	1 and Healt sem 2		Kay F. Ferrell (Wi	.te)	20b. Place of Dispo	sition (Name of	Ave., Balt		MD ZIZIS 20c. Location - City	or Town, State
õ	Pages nent of ent: If It ury or o		1 □ Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	lemoval from State	Garrison Cemetery	natory or other p Forest				, Maryland
Baltimore,	그 든 번 글		21. Signature of Funeral Service Licens			2. Name and Add			ark Funer	
ä	Depa Impo		1/2			3620 Wil	kens Ave.,			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused						Approximate Interval Between
	Physician	e y	Immediate Cause (Final disease or condition	Vont	i cul con	Tod	1 .	a		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1	1. 0	Α `		
	CAGIIIIIEI	L	Sequentially list conditions,	. Asker	rosclev	tic	Heaut	duse	ore.	yeary
	led sit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					0,000
	axecurand and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					Jeurs.
68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	cal E	L.	1.						
99	tificat ng phy as th	led								
Вох	leath certific attending pl	an/N	23b. Was decedent pregnant	3c. If yes, outcome		Ectopic pregnar	nev		23d. Date of	
_	he att	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
P.0	res that the de signed by the a be detached f		9 ☐ Unknown Part II. Other significant conditions cor	stributing to death by	ut not resulting in the u	ndorhina couco	given in Best I	23a Did tol	na oca uso contribut	to the cause of death?
Records,	signe d be c	d by	Tattii. Stior significant conditions con	ithibuting to death bi	at not resulting in the u	nderlying cause (given in Fait i.	1 □ Ye		Probably 4 Unknown
20	w require been sign	Completed						24a. Was a	-	
Re	sician: The law s certificate has b irector, page 2 s	пр						autops	ned? prior death	autopsy findings available to completion of cause of 1?
Vital		a	25. Wa ase referred to medical				26. Place of Deatl		2 2 No 1 1 Y	es 2□ No
Ξ	Physician: this certifical director.	ToB	examiner?	lospital:	nt 2 ER/Outpatier	at 3 DOA)thor		ence 6 ∐Other (S	(pecify)
n of	Attending Physician: or death. ector: After this certific by the funeral director.		27. May ler of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o	28c. In	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ow injury occurred	,
Sio	Attending r death. sctor: After by the funer	catlo	2 Accident investigation				☐Yes 2☐No			
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubus	ury - At home, farm, str c. (Specify)	eet, factory, offic	8	28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	pital ours a erel D		29a. Certifier 1 Certifying Phys	riping. To the boot o	of my knowledge, death		diagram de la contraction de l			
	Hos 24 hc Fun etely i	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	of my knowledge, deatl examination and/or in ited.	vestigation, in my	y opinion, death occurr	ed at the time, da	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier		-	29c. Lice	nse number	2:	9d. Date signed (Mo	onth, Day, Year)
			I jami Illia	lu _		2)6	0021730		Feh	2 2005
	NXI		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,	Print)				
	0,		SIAMAI HOSPITAL	NORTHERN	MARKWAY	BALT	nse number DOD(730 MMRE, M	4		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	Signature /	Sparks				
	Registr	ar	FEBU	(COOD	To Charles And	- 8				

			1- Roystate State of Maryland / Department of He Registrar 23a per Dr., G840 continues 25th	ealth and Me		ene g. No. 2005	0341	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mary J. Freshour (aka Mary Z. Freshour)		2. Date of Death Month January	Day Year 29, 2005	3. Time of Death 3:40p	
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Home 5. Social Security Number 1 \square M 2 \square F 216-18-9876 4b. City, Town, or I	11e If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, ug. 16,			
e, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 23 or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at	To Be Completed by Funeral Director	Milton D. Zahn 19a. Informant's Name/Relationship (Type, Print) Mary N. Fitzgerald (Daughter) 2 Casey Court,	Mexican, Puerto R Specify: ion iring most of working 18. Mother's Name (Emma and Number or Rural Baltimore	D. (First, Middle, M. Route Number, e., Mary.)	6b. Kind of Business/I epartment laiden Sumame) Buch City or Town, State, Zi land 21228	ican Indian, b, etc. hite Industry Store Ip Code)	
Baltimore,	permit. Pages 1 a Department of Hea Important: if item any injury or othe		20a. Method of Disposition 1 St Burial 2 □ Cremation 3 □ Removal from State 1 Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place, Carrison Forrest Veterans Cemetery) 21. Signature of Funeral Service Licensea 22c. Name and Address	2/8/05 of Facility Lou	5 Ba	oc.Location-City or 1 altimore, M ck Funeral ore, MD 212	Maryland Home	
8760,	Physician and was content with the prival-transit	cai Examiner	23a. Part terms the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Pue to (or as a consequence of): Due to (or as a consequence of): But the cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. HIN with Ne hrosc1 Due to (or as a consequence of):	hvive			Approximate Interval Between Onset and Death	
P.O. Box 68	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yes 2 Yes 2 Yes 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of deliving Month	Day Year	
Records,	w requires the been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	1 ☐ Yes	acco use contribute to	the cause of death? bably 4 DUnknown	
al Rec	The ate h page	Completed			·	prior to co death? No 1 \(\sum Yes\)	opsy findings available empletion of cause of 2 No	
on of Vital	ng Phys ter this neral di	ıtion; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Injury Work? 28b. Time of Injury Work?	TO Nursing Home	e 5 ☐ Resider) ice 6 ⊡Other (Speci v injury occurred	(fy)	
Division	tal or Attendir rs after death. at Director: At	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office 28f. I				
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated. 29b. Signature and title of certifier 29c. License in	nion, death occurred	at the time, dat	use(s) and manner as see and place, and due to d. Date signed (Month,	to the cause(s)	
	\0			0303 stille r		2/2/5	5	
	Sta	ate	31. Date filed (Month, Day, Year) STEB 0 7 2005 32. Register's Signature FEB 0 7 2005	stille r	1021	723		
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			1 - For State Registrar	State of	Maryland / [-	artment <i>tificate</i>			and M		250	arts of a server	031.18
			Decedent's Name (First, Midd	fle, Last)		007	imoure	- 01 2	Jean	-	2. Date of Dea	Reg. No	.000	3. Time of Death
	Physici		MELVA	LEE G	REENE						Month Februar	Da		4:01 a M
	/Medi Examir		4a. Facility Name (If not institution				4b. City, 7	Town, or	Location of	f Death			. County of Death	4.01 a
			1813 BEECHWO	DD AVENUE			BALT	IMOR	E				N/A	
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. last birt		If Under	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)		place (State or Foreign
	Director		214-40-2503	1 N 2624	62	Yrs.					Januar			MARYLAND
	land		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town	or Lo	cation							10d. Inside City Limits
	Many f sh	ō	MARYLAND N/A		DAT	шти	1ORE							1 ☑ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number		DAL	11 11.	10f. Zip	Code				10a. Cit	tizen of What Cou	ntry?
	th with		1813 BEECHWOO	D AVENUE				212	207				U.S.A.	95
	ams ams	Funeral	11. Marital Status	12. Was Deced		13. V	Vas Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ameri	
36	s afte	by Fu	1 Never Married 2 Mar	rried 1 ☐ Yes 2 If Yes, Give	∑ No		Yes 2		Specify:	, ruento	nican, etc.)		Black, White,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Itams 23e or 28e-f show evant, the Madical Examiner must be notified at		3 X Widowed 4 □ Divorced	Year or Date									PL	ACK
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212	d within jiene. r than "	mo mo	Elementary/Secondary (0-12)	College (1-4			ION C	,		R		BA.	LTO CITY	SCHOOLS
b	be filed within tal Hygiene. d other than '	BeC	17. Father's Name (First, Middle,								(First, Middle,			Бенеедр
/lai	2 should be and Mental is marked (samarice)	To	MELVIN POWELL						DOI	ROTH	Y MILLE	R		
lar	2 shoul and Me is mark aumati		19a. Informant's Name/Relations	ship (Type, Print)	19b.	Mailin	g Address	(Street a	n <i>d Number</i>	r or Rura	l Route Number	r, City o	or Town, State, Zip	Code)
	D = 2 = □		Gaarland E. Ha	ll/Friend					od Ave			re,	Maryland	1 21207
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from Sta	20b. Place of cemeter	Dispos v, crem	sition (Name atory or oth	e of her place)	D	ate	20c. Lo	ocation - City or To	own, State
Ē	permit. Pa Departmen Important: any injury ance.		`4 □Donation 5 □ Other (S	Specify)	ARBUTU				1	02-1				MARYLAND
Ba	permit. Pag Department Important: I any injury o		21. Signature	Dining	1						MUNITY	FUNI	ERAL HOM	E P.A.
			23a. Parte. Enter the disease, o	r complications that cau	sed the death. Do n	12 ot ente	06 W	NOR'	Such as c	ENUE	r respiratory arr	est .		Approximate
W			23a. Partt. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	2		1			A					Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	a	as a consequence of		men	MIC		14pi	100 mA			
P	Examiner		Conventially list one distance	b		-,-								
	ס .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionying Cause (Disease or injury		as a consequence o	f):								
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687	ficate phys s the	dical		d										
Box (eath certific attending p for use as	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnancy								23d. Date of delive	in.
m	death e atte d for	icla	in the past 12 months?	4□Pregnan	n 2 ☐ Fetal death t at time of death		Ectopic pred Other (spec					1	Month	Day Year
0	that the de ted by the a detached t	hys	9 □ Unknown	9□ Unknow	n									
S,	igned be de	by Physiclan/Me	Part II. Other significant condition	ons contributing to deat	h but not resulting in	the un	derlying cau	use giver	n in Part I.		23e. Did tol	oacco u	ise contribute to th	e cause of death?
מ	w require been si should b										1 □ Ye	es 2[□No 3□Prob	abiy 4 Dunknown
Records,	has be	ompleted								_	24a. Was a autops		24b. Were auto	osy findings available inpletion of cause of
		Con									perform	ned?	death?	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?							of Death	(Check only on	e)		
	Physi this c al dir	7	1 ☐ Yes 28 No	Hospital:			-	_	4 🗀 14012				5 □Other (Specify)
L O	ding l h. After funer	tlon	27. Manner of Death 1 Pandir 1 Pendir		njury 28b. Ti Day Year) In	me of jury	M 286	work?	at ∋s 2.⊡No		8d. Describe ho	w injur	y occurred	
Division of	or Attanding Physicien: after death. Diractor: After this certific i in by the funeral director.	fica	2 Accident investi	not be an Black of	Injury - At home, far	n. stre		7.77.4	22 5 14		8f. Location (St.	reet an	d Number or Rura	l Route Number
5	al or a	Certification:	4 Homicide determ	building,	etc. (Specify)	.,	,,,	000			City or Town	, State,)	riodie i variber,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral		29a. Certifier 1 Certifyir	ng Physician: To the be	st of my knowledge,	death	occurred at	the time	, date and	place, a	nd due to the ca	use(s)	and manner as st	ated.
	the H in 24 the Fu	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examination and	or inve	estigation, in	n my opii	nion, death	occurre	d at the time, da	ate and	place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	r			29c.	License	number		25	d. Date	e signed (Month, I	Day, Year)
	2		Multe	D my	>		<u> </u>	730	20 pc			3	7101	
	10		3	who completed cause of						***				
	√ Sta	to	31. Date filed (Month, Day, Year)	32 Tegi	strar's Signature	4	mor	2	MY	a	1730			
	Registr		31. Date filed (Month, Day, Year) FEB 0 7	2005	in the	God	de							

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#1,perFit,Co40,2//05 II
State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #5 PER INF G840 2791103161107 Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Earline Gainey Day Month **Physician** ERLENE 11300 FEBRUARY 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner BALTIMORE CIT CARF CENTER JOHNS HOPKINS 9. Birthplace (State or Foreign Country)
SC If Under 1 Year If 8. Date of Birth (Month, Dey, Year) 04-30-1919 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 M 2XX 85 Director Usuel Residence of Decedent the Manyland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b, County rel', or Items 23a or 28a-f ehow Examiner coust be notified at 1 ☐ Yes 2 ☐ No MD N/A BALTIMORE Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2537 W. FAYETTE STREET 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after ☐Yes \$_No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify BLACK Completed by 3 ♥ Widowed 4 Divorced Year or Dates: "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY 8 FACTORY WORKER 18 Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othery jury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) Be JOHN SAUNDERS ANNA COLEMAN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE TATE/GREAT NIECE 839 N. FULTON AVENUE, BALTO., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/08/05 BALTO., MD * 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee ames Lin 1701 LAURENS ST., BALTO., MD 21217 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 1160 R /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit l or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Month 4 Pregnant at time of death 5 Other (specify) detached he Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe EMENTIA 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of eath Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1001889 FEBRUARY 2, 2005 0202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS BAVIEW CIRCLE BALTIMORE NO 21224 BURTON 5505 NHOC 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Décedent's Name (First, Middle, Last) Month **Physician** 9:22 AM CORA JANUARY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 74 1 M 2 F West Virginia Director 216-24-5603 18. 1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Finksburg Maryland Carroll Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA or Items 23a 21048 1283 Wesley Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itan any injury or other traumate. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 AWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Computer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Barker (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1283 Wesley Rd., Finksburg, MD 21048 Earl E. Gray Jr., (Son) 20b. Place of Disposition (Name of cometery, crematory or other place)
Baltimore Crematory
C Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 2/6/05 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** 23 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed use as the burial-transit QUAMOUS that initiated events resulting in death) Last P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CHRONIC 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? r this certificate has ral director, page 2 2 12 No 1 ☐ Yes 2 ☑ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident within 24 hours after death

To the Funeral Director: ,

completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number KARUNA POSANIMO #AS2441614 B29 Karina JANUARY 31 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21225 3001 SOUTH HANOVER STREET, BALTIMORE POSANI 32. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar flow It fale

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:30 PM Month **Physician** SIDNA ELIZABETH PAMILLA GASKINS 02/03/05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIDGEWAY MANOR NURSING HOME CATONSVILLE
If Under 1 Year If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2♥F 94 214-24-5803 07/16/1910 MARYLAND Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits XXYes 2 ☐ No N/A BALTIMORE CITY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3306 EGERTON ROAD 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$ TN If Yes, Give 1 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3√ Widowed 4 Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANKLIN E. JONES 2 ANNIE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE ST, BALTIMORE, MD 2 20c. Location - City or Town, State ANDREW GASKINS / SON 2106 E. MD 21231 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) MD NATL MEM PK. 2/8/05 LAUREL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee THE THE LET SE, Or complications that caused the math. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. 4600 LIBERTY HEIGHTS AV. BALTIMORE, MD Approximate Interval Between Onset and Death Due to (or at a consequence of): Imm Jate Cause (Final Source or condition resulting in death) yeons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced the cause of the cause o Due to (or as a consequence of). Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ directiculares 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 | Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed use as the burial-transit attending physician and Division of Vital Records, P.O. Box 68760 funeral After within 24 hours a

Funeral

Director

7 is marked other than "neturel", or items 23a or 28a-f show treumatic event, "te Madical Examinar must be notified at

permit. Pages 1 and 2 should be fill Department of Health and Mental H Importent: If Item 27 is marked ott any injury or other treumatic even

Physician

Examiner

/Medical

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Geether Leyer WD

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GETHA RAIA WD, 4367 HOITING FLORY RA 32. Registrar's Signature

Baltinery, MD-21227

29d. Date signed (Month, Day, Year)

Feb 7, 2005

ORIGINAL

29c. License number

D27541

			State of Maryland / Depa 1 - State Registrar AMEND ITEM #2 PER DVR G840 2/66	rtment of Health and M	lental Hygie	•	03423			
	 Physici	an	1. Decedent's Name (Pirst, Middle, Last)		Date of Death Month	Day Year	3. Time of Death			
	/Medic Examin	al	JAMES E. GILLIAM 4a. Facility Name (If not institution, give street and number) 127 S. CLINTON STREET	4b. City, Town, or Location of Death	FEB. 3,	2004 2005 4c. County of Death N/A	9:30am ^M			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217 82 4339 1 1 2 M 2 □ F 41 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.						
	show ed all		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10	Od. Inside City Limits			
	a-fsh	tor	MD N/A BALTIMORE				1X Yes 2 □ No			
	th with the 23e or 28 ist Le not	al Director	10e. Street and Number 127 S. CLINTON STREET	10f. Zip Code 21224		Citizen of What Coun	try?			
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artinent of Health and Mental Hygene. ortent: If item 27 is marked other then "naturel", or items 23e or 28a-f show injury or other traumatic event, the Madical Examiliar matter and the published at a.g.	Completed by Funeral	1 TVNever Married 2 □ Married 1 □ Yes 2 X No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2∏ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, a Specify: BLA	etc.			
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	and 2 st ealth and m 27 Is n		SELENA STOKES (MOTHER) 127 S.	CLINTON STREET BA	ALTIMORE,	MARYLAND :	21224			
Baltimore,	Pages 1 nent of H ant: If ite ary or otl		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	RIAL PARK FEBRUA	ARY 9, 20	0c. Location - City or To	MARYLAND			
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ds, P.	uires that signed b	d by PI	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to the				
I Records,	The lay ate has page 2	Complete			24a. Was an autopsy performe	prior to con	psy findings available apletion of cause of			
Vital	icien: certific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	. /					
of	0 - 0	Thin patient 2 Levo dipatient 3 Dook 4 Thursting Home 32 Residence 6 Dottner (Specify)								
Division	after dea Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 2 Medical Examiner: On the basis of examination and/or invalid manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurred	and due to the cau ed at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)			
	To the To the Comp	Ĭ	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month, L	Day, Year)			
•			P WPAULUCK MD	154900C	4 FE	eburary L	1,2008			
\	4		30. Name and address of person who completed cause of death (Item 23a) (Type, FEDDY BULLOW FULLY)		altimor	e MD ZI	216			
		State Registrar FEB 0 7 2005 32. Registrar's Signature								

			For Stata Registrar		State o	f Maryl		artment of H		nd Me		iene 2	005	03421	L
			1. Decedent's Name	(First, Middle, Las	st)					2.	Date of Deat	h		3. Time of Death	_
	Physici /Medic		Helen	E1i	zabeth		Hick	nan		Ja	Month anuary	Day 23. 2	Year 1005	1:20 p M	
	Examin		4a. Facility Name (If I	, ,	street and nu	mber)		4b. City, Town, or	Location of I				ity of Death		_
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	Funeral Director		5. Social Security Nur 219-16-89	1	9X □M 2 <u>X</u> □F		yrs. last birthday) Yrs.	Months Days		Min.	Date of Birth (Month, Day,			place (State or Foreign ntry)	
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	nylan bow	_		10b. County			. City, Town or Lo							10d. Inside City Limits	
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	with the		10e. Street and Numl					10f. Zip Code	_		10	0g. Citizen o	f What Cou	ntry?	
	leath	Funeral	1801 CI	ark Blvd	12. Was Dec	edent Ever	n U.S. 13.1	Vas Decedent of Hi		n2 (Specify	Ves or No-	USA	ace - Ameri	can Indian	_
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f ehow eny injury or other treumatic event, the Modical Eventer must be notified at once.	by Fun	1 ☐ Never Marrier 3 ➡ Widowed 4	_	Armed For 1 Yes If Yes, Gir Year or D	orces? 2 [★No ve		Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 → No	n, Mexican, F Specify:	Puerto Ric	an, etc.)		ack, White,		
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_	uted d ansit	Examiner	Sequentially list conditions, leading to immoduse. Entire Unidentical Cause (Disease or in that initiated events	ying njury											
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o.	that the de ned by the a detached t	Physician/Me	1 □ Yes 2 🔀 9 □ Unknown	No	9□ Unkn		ordeath 5	Other (specify)							
۵.	law requires that the death certifi as been signed by the attending r.2 should be detached for use as	by Ph	Part II. Other signific	ant conditions c	ontributing to d	eath but not	resulting in the ur	iderlying cause give	n in Part I.		23e. Did toba	acco use cor	ntribute to th	ne cause of death?	
rds	v require been sig should b	ed b								_	1 ☐ Yes	2 XN0	3 🗌 Prob	pably 4 □Unknown	
Records,	aw requas been 2 should	Completed									24a. Was an	24b.	. Were auto	psy findings available	
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nc	After fune	llon:	27. Manner of Death 1 Natural	5 Pending	28a. Date (Mon	th, Day Yea	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2.⊡No		. Describe how	v injury occu	irred		
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2	al or A after I Direct	Certification:	4 Homicide	determined		ing, etc. '(Sp		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,				ì
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical (29a. Certifier 1 (Check only 2 one) 2	Certifying Ph	iner: On the b	best of my asis of exan	knowledge, death nination and/or inv	occurred at the time estigation, in my op	e, date and p inion, death	place, and occurred a	due to the cau	use(s) and m	anner as si , and due to	tated. the cause(s)	
	To the within To the comple	Me	29b. Signature and til	tle of certifier				29c. License	number		29	d. Pate sign	ed (Month,	Day, Year)	-
	12) (0	NN	1		_	D3	SOS	4		1/24	05		
	A		30. Name and address	ss of person who	completed caus	se of death (Item 23a) (Type,					1,4,1	1~7		_
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	Sta Registr		31. Date filed (Month	FEB 0	7 2005	egistraf's S	gnature As	1							

		1	State of Maryland / Department of Health and Mer State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygien Reg. N	
				Date of Death Month D	ay Year 3. Time of Death
	Physicia /Medic	_	LOUIS HARTZELL	ANUARY	23 2005 3:55 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death
			HARBOR HOSPITAL CENTER BALTIMORE 5 Soviet Secretary Winners 6 Sov. 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	. Date of Birth	n/a 9. Birthplace (State or Foreign
	Funeral		Months Days Hours Min.	(Month, Day, Yea	r) Country)
	Director	-	212-28-2479 74 11s. Aug	g. 13, 1	930 Maryrand
	yland	-	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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	th the)lrec	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Country?
	23a	ral	406 Fernglen Ave. 21061	fy Vos or No-	USA 14. Race - American Indian,
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Richard Cuban, Puerto Richard Cuban, Puerto Richard Cuban, Puerto Richard	can, etc.)	Black, White, etc.
36	rs aft	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: White Year or Dates:		Specify: white
21215-0036	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show diest Examiner must be multified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		Kind of Business/Industry
215	within 7. ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager		me Mutual Life Ins.
21	e filed within al Hygiene. I other than '	Col	12th		
Ind	be fill d oth	Be	17. Father's Name (First, Middle, Last) Walter Hartzell Ethel Pi		
2	2 should be f n and Mental H is marked of raumatic eva	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F		y or Town, State, Zip Code)
Maryland	d 2 sl th an t7 is r traur		Suzanne L. Smith- Daughter 1476 Pleasantville Dr.,		
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-f show itam traumatic evant. If a Midle Levin in an inside the multilist at a other traumatic evant. If a Midle Levin in an inside the multilist at a content traumatic evant.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	te 20c.	Location - City or Town, State
OE .			1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery Jan. 2	7, 053a1	timore City
Baltimore,	permit. Page Department of Important: If any injury or once.	İ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loud		
ä	Ped E and		KM Achlungel 3620 Wilkens Ave. Ba		Maryland 21229 Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Interval Between Onset and Death
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Box	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
P.O. I	the a	ysic	1 Yes 2 No 9 Unknown		
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Re	The la ate has page 2	Completed		performed	death?
ta		0	25. Was case referred to medical 26. Place of Death		
\	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom		
0	ding Phy h, After thi funeral		1 Matural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how i	njury occurred
Sio	tandi leath, tor: A	cati	2 Accident 3 Suicide 6 Could not be 290 Place of Injury - At home farm street factory office 21		t and Number or Rural Route Number,
Division of Vital Records,	or At after o Dirac in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, S	tate)
	To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the caus d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 thin 2 tha	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	FRES		Mathecen Sterlis, M.D. (Intern) RES 000	JA	NUARY 23, 2005.
	nxi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		2 2
	. (1 ,		Kathleen Sterbis 2721 Knapps way odenton 31. Date filed (Month, Day, Year) FEB 0 7 2005 Market & Special Street	MP	41113.
		tate	31. Date filed (Month, Day, Year) 32. Hegister's Signature		
	Regis	traf	LEB O I CODY L'ACCESSOR DE 19		

			-2	State of Maryland	CK Indelible Ink. Department of He	•	
			1 - State Registrar	The state of the s	Certificate of D	ooth	Reg. No. 2005 03426
	Physici /Medic	al	Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give s	OVISH	4b. City, Town, or L	2. Date of De Month	Dey 3 1 Yeer 3. Time of Death 3. Time of Death 4c. County of Deeth
i.	Examir	ier	Forest Haven	M 11	ne Catons	ville	Baltimore.
	Funeral Director		5. Social Security Number 6. Sex			If Under 24 Hrs. Hours Min. 8. Date of Bir (Month, Date of Date)	th 9 Birtholace (State or Foreign
	e Maryland la-f show	ctor	10a. State 10b. County MD Baltimor	,	own or Location tonsville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with th	i Director	10e. Street and Number 210 North Altamont	t Street	10f. Zip Code	228	10g. Citizen of What Country?
36	72 hours after death with the Maryland natural', or items 23s or 28s-f show disal Examination in the reditied at	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		panic Drigin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	USA 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ane. then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16	6a. Decedent's Usual Dccupati (Give kind of work done du life. DO NOT use retired)	on ring most of working unk	16b. Kind of Business/Industry unk
yland 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Paul Harish		1	8. Mother's Name (First, Middle,	, Meiden Surname) unk
Mar	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Type Forest Haven Nurs			d Number or Rural Route Numb Avenue Catonsvi	er, City or Town, State, Zip Code) -11e, MD 21228
Baltimore,	Peges 1 end 2 should tent of Heelth and Mer int: If item 27 is marke iry or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. Place ceme	of Disposition (Name of tery, crematory or other place)	Date	20c. Location - City or Town, State
Baltii	permit. Peg Department Important: any injury o		21. Signature of Euneral Service Licenses ROng I C		State Anaton Baltimore,	my Board 655 W.	Baltimore Street
T. T.	Physician /Medical		23a. Part Enter the disease, in complication of the complication of the complication of the complication of the complication of the complete comple	cations that caused the death. De cause on each line. Due to (or as a consequence	IC HEPAT	such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
760,	te be executed ysicien and burial-transit e burial-transit entry	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence			
.O. Box 68	The law requires that the death certificate ite has been signed by the attending physionage 2 should be detached for use as the table.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year
<u>α</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause given		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Hinknown
of Vital Records,		Completed					
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/	Dthec	26. Place of Death (Check only of	
	Attending Phy r death. ector: After this by the funeral d	-	27. Manner of Death 1 Natural 2 Accident investigation		o. Time of 28c. Injury a linjury Work?	t 28d. Describe I	dence 6 (_)Other (Specify) how injury occurred
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (: City or Tox	Street and Number or Rural Route Number, wn, State)
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowled her: On the basis of examination and manner stated.	ige, death occurred at the time, and/or investigation, in my opin	date and place, and due to the lion, death occurred at the time.	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A state	29c. License r	number	29d. Date signed (Month, Dey, Year)
			Jarneur	Laleham	D 2	8575	1/31/05
			30 Name and address of person who co	mpleted cause of death (Item 23)	a) (Type, Print)	terater Aug	BARD MA 2122 B
	Sta	ite ar	31. Date filed (Month, Day, Year) FFB 0 7 2005	32. Registrar's Signature	South .	1990 P	1011) 24208

			Please	State of Ma					•		egible.	
			1 - For State Registrar	Otato or mic	•	Certificat			, a montan	Reg. No.	005	03427
			1. Decedent's Name (First, Middle, Las	it)					2. Date o	Death	Voor	3. Time of Death
	Physici /Medic		Sofron Ha	4 kowse	~				Jay	3 g	2005	8:35 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death		ounty of Death	
		•	Union Hospital	of (ecil	County	2	1K-1	rou			ecil	
	Funeral		5. Social Security Number 6. Social Security Number 1 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex 7. Age DXM 2□F	e (In yrs. last birt	hday) If Under Months	1 Year Days	If Under 24 Hours	Min. (Month	Birth Day, Year)	Cour	
	Director		Usual Residence of Decedent	-21	63	115.			NOV.	8,194	41 UK	RAINE
	land ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Many -f sh lied	tor	MD. CECII	1	PO	RT DEP	osii	ר				1 ☐ Yes 2 No
	h the	lrec	10e. Street and Number			10f. Zip	Code			10g. Citize	n of What Cou	ntry?
	23e c	alD	427 BAINBRIDG	SE ROAD			219				S.A.	
	r dea	ne	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Origi n, Mexican,	n? (Specify Yes o Puerto Rican, etc.	r No- 14	 Race - America Black, White, 	
36	within 72 hours after death with the Maryland one. then "neturel", or items 23e or 28e-f show the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 ☐ N If Yes, Give	∾ 963–65	1 Tes	2 X No	Specify:		S	pecify:	ITE
21215-0036	hour	ed t	15. Decedent's Ed			Decedent's Usua	al Occupa	ation		16b. Kind	of Business/In	
15	in 72 in "ne	Completed	(Specify only highest gra			(Give kind of wo life. DO NOT us	rk done d	furing most o	of working			•
212	d with	E O	Elementary/Secondary (C 12)	2	, ,	SUPER	VISC	R		WAF	REHOUS	E
	be filed ital Hygir d other event,	Be	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Mic	ddle, Maiden Si	umame)	
yla	should be filed within and Mental Hygiene. is marked other then eumetic event, Ite M.	2		NKEWYCZ						UTKA		
Maryland	2 sh and ism reum		19a. Informant's Name/Relationship (or Rural Route No			
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, I'te Medical Exeminar must be notified at		ROMAN HANKEWYCZ 20a. Method of Disposition	/ BROTHE	20b. Place of	Disposition (Nar	ne of	1	ENUE, BA		KE, MD. ation - City or To	
Baltimore,	Pages nent of I int: if it		1 ☐Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific	Removal from State		y, crematory`or o		1	NTT 7 NT 2 /	1/05 5		ODE WD
量			21. Signature of Funeral Service Licer		DI. M	22. Name an	d Addres	s of Facility	NIAN 2/			
ä	permit. Departr Importe any inji		- Contraction	X	-	1901	2 & 72 & T	EILEI ERN	R INC. AVENUE,	FUNERA	L HOM	E 5 21221
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do n	not enter the mod	le of dying	g, such as ca	ardiac or respirato	ry arrest,	OILETIN	Approximate Interval Between
	Physician	ļ	Immediate Cause (Final disease or condition	Asyc.		Caldi		Store	dst.11		/	Onset and Death .
	/Medical		resulting in death)	Due to (or as	a consequence of		41	1 4 40			- 0	
10	Examiner	١.	Sequentially list conditions.	b. // //	er K	1cus	4					2 days
	pe jis	iner	Sequentially list conditions, it any, it and it is cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of	ot):	T	-/				1
_	ite be executed ysician and ne burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	C441	1 9	? [[\	<i>C</i>			Weak
760	s be e	calE		d								
89	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit											
Box	h cert endin	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 ⊟Ectopic p	regnancy			23	d. Date of deliv	-
	e deat ne att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		5 Other (sp					Month	Day Year
P.O.	that the death ed by the atte detached for	Completed by Physiclan/Med	9 Unknown Part II. Other significant conditions of	contributing to death b	ut not reculting in	the underlying a	auco aire	on in Part I	23a I	Oid tobacco use	e contribute to t	he cause of death?
S,	w requires that been signed to should be det	by	Met significant conditions	Aderoca	_		1.	me c	,	I □ Yes 2 □		- /
Ö	requ been should	etec	144 1 - 6	4- 7	- 6	1_0(110	774 6		Was an	24h Word auto	opsy findings available
Records,	The law cate has page 2 s	dm	Marigarit	113017	-6)					outopsy performed?	prior to co death?	mpletion of cause of
E		e Co	25. Was case referred to medical					26 Place o	of Death (Check o		1 🗆 Yes	2 L No
>		O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatie	ent 2□ER/Ou	tpatient 3 DC	Othe Othe	0.5	sing Home 5 1		Other (Specia	(y)
Jo (ding Phys h. After this funeral di	T:u	27. Manner of Death	28a. Date of Inju (Month, Da	rv 28b. T	Time of 2	28c. Injury Work	at at		ibe how injury		
Sio	Attending in death.	atlo	1 Natural 5 ☐ Pending investigation	n		М		Yes 2 □ N	0			
Division of Vital	ter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of Inj	ury - At home, fa c. (Specify)	rm, street, factor	y, office			on (Street and i r Town, State)	Number or Run	al Route Number,
	urs al srel D	S	CO- Continue 15 Continue Di	walsies. To the best	of my knowledge	dooth assumed	01 th - ti-	dot	place, and due to	the enverte		totad.
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu	ledical	29a. Certifier 2 Sertifying Pr (Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	f examination and	d/or investigation	at the time, in my of	ne, date and pinion, death	place, and due to occurred at the ti	me, date and p	nd manner as s lace, and due t	o the cause(s)
	o the	Med	29b. Signature and title of certifier	1				e number			signed (Month,	
	P > P 0		· My aphi	Jun .		I	000.	551	90	Jon	29	2007
e<,	0		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, Print)		- •		- 02 -7		2005 Am, MD
1	1		Alfred A Pi	am en	Union	Hor	pita	1 10	6 Bow	5+ 8	ElKto	AM ro
		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature							,
	Regist		FES 0 7 20	05	and for	(part)						
Dł	HMH 17 Rev 1/2	2001			ORIO	GINAL						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 5, 2005 1:30 AM M Walter Isennock /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Dundalk Baltimore 1706 Holaview Road #B4 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb 7, 1960 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days Hours Min. 1፟M 2□ F Maryland 44 Director Yrs. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1706 Holaview Road #B4 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cab driver transportation of Health and Mental Hygie of Health and Mental Hygie if Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Holaview Road #B4 Dundalk, MD Joyce Gingher/friend 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Its
eny Injury or ott 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 🛛 Other (Specify) in State 21. Signature of Euneral Service Licensee
ROnald S. Wade, Director
State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Partl. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** C.O.P. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): physician and s the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours To the Funeral Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatur and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) who completed cappe of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date Sied (Month, Day, Year) 32 istrar's Signature State 07 2005 Registrar

Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

amend item#20b-c, perFH, G840, Z/7/05 TI
State of Maryland / Department of Health and Mental Hygiene, On F 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day ã Physician RENE 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3720 TRK AUE

7. Age (In yrs. last birthday) ACTIMORE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month Day) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-14-4674 1 M 2 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ahov other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director BALTIMOK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3720 454 or Items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 PNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: BLACIK Specify: 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

LAURER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nnt: If itam 27 Ia marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) 1274 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: If itam 27 la any injury or other trauonce. 3721 46W.44D MD 21207 20b. Place of Disposition (Name of company, operator) of the classical company 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State MD 4 ☐ Donation _ 5 ☐ Other (Specify) yneral Service Licensee 21. Signatu CIMENTY Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Sheet and Death Immediate Cause (Final distance or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a conse ence of: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760. the attending physician and ience of): by Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Dunknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 2 No 1 Yes or Attending Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Director: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier License nymber 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Boateno W 31. Date filed (Month, Day, Year) 32. Registar's Signature

DHMH 17 Rev 1/2001

State Registrar

FEB 07

2005

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of Hertificate of E		, ,	iene	0.5	031.30
	Physici /Medic		1. Decedent's Name (First, Middle, Last CLEMENTINE			び	ONES	2. Date of Deat Month	Day	Year	3:58 PM
	Examir		4a. Facility Name (If not institution, give Johns Hopkins 1	street and number)	Hospital		more		4c. County	of Death	
	Funeral Director		5. Social Security Number 220-36-2442 Usual Residence of Decedent	x 7. Age	70 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 12–26–1		Country	e (State or Foreign) MD
	the Maryland 28a-f show notified at	ctor	MD 10b. County BALTO.		10c. City, Town or Lo					10d.	Inside City Limits
	with th	I Dire	10e. Street and Number 124 HIGHSHIRE CT.			10f. Zip Code 2122	2	1	0g. Citizen of V		?
036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show he Mcdical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N I I Yes, Give Year or Dates:	lo	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No- Rican, etc.)	Blac	BLACK	
21215-0036	/ithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Edu (Specify only highest grad	ucation le <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of working	ng	16b. Kind of Bu	siness/Indus	try
	be filed tal Hygi d othar evant, I	To Be Col	17. Father's Name (First, Middle, Last) THOMAS BURMAN	4	CHIL	D CARE SP	ECIALIST 18. Mother's Name MINIE R			STATE e)	
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (T) CHARLISE FLOURN			2005 REA					
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cres)	ate	20c. Location -	City or Town	, State
Baltin	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licens		22	Name and Address Name LAURE	2/09/ s of Facility JAM NS ST., B	ES A. M	BALTIMO ORTON & MD 2121	SONS	F.H., INC
	Physician	0	23a. Part Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each lir	the death. Do not ent	er the mode of dying				Ap	pproximate terval Between nset and Death
8760,	Medical Examiner physician and the purial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause from underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Bac-	a consequence of): teremia a consequence of): a consequence of):						1 day
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	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death bu		nderlying cause giver	n in Part I.	23e. Did tob	acco use contr s 25 4 No	ibute to the d	
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Vita	ysiclan: s certition director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₹ No	Hospital:	nt 2 ER/Outpatier	Other	26. Place of Death			er (Specify)	
Division of	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Diractor: Atter this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28c. Injury Work	_ ,	8d. Describe ho		(-17/	4-72-7-7-7-7
Divis	To the Hospital or Attand within 24 hours after death To the Funeral Diractor: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc				8f. Location (Sti City or Town	, State)		
	n 24 hou n 24 hou he Fune bletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	of my knowledge, deatl examination and/or in ted.	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	nd due to the ca ad at the time, da	use(s) and mar ite and place, a	nner as state and due to the	d. e cause(s)
	Within Comp	W	29b. Signature and title of certifier MR	٠٠١ , ٨	N	29c. License	62560) Fe	d. Date signed	(Month, Dey	, Year) 2005
	10		30. Name and address of person who co Milmel Drummon	D 1830 1	eath (Item 23a) (Type, East Nonvo	Print) Street,	5th Floo	r Balti	more, M	arylan	d 21287
	Sta Regist		31. Date filed (Month, Day, Year)	on the grade	s Signature	Aparle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND TTEM #5 PER FH C840 2 Gentificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Phillip Ernest Johnson IANUAR /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALT More TFAUTEANTE n/a If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1X M 2 □ F Director 1921 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23e or 28e-f show other treumatic event, the Medical Exprendent must be notified at 10d. Inside City Limits Director No Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Taylor Ave. catonsville, Maryland 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? ↑X□ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If Item 27 is marked other than "natural", or Itel 1 Never Married 20XMarried Baltimore, Maryland 21215-0036 Black Black. 1 ☐ Yes 2 ☐ No by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Shipper Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Cora Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Johnson- wife 404 Taylor Ave. Catonsville, Mayland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages I Department of F Importent: If Ite any injury or ott 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery Feb. 3,05 Baltimore City 21. Signatury of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 05 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivers 2 Fetal death in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2□ No 1 Yes 200 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho To the Fune completely f (Check only one) 29b. Signature and title of certifier 29c. License number 120001 30. Name and address of person 10 no completed cause of death (It m 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2005

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment ertificate			and Me		giene	05	00100	
			Decedent's Name (First, Middle, Last	st)						2. Date of Dea	-	U-)	3. Time of Death	
	Physici		Josephine			т.	ohns	on		Month	Day 7	Year	1550 M	
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)				Location o		1001000		ty of Death	1330	
	LXdiiii	iei	Augsburg Luthe	eran Nurs	sina Hom	e B	alti	imore	e					
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda) If Under	1 Year	If Under	24 Hrs.	8. Date of Birti	h ,	9. Birthr	place (State or Foreign	
	Director		213-22-0563	□M 2□XF	90 Yrs.	Months	Days	Hours	Min.	(Month, Day		Cour	VA	
	D		Usual Residence of Decedent											
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	B Ma	cto	MD NA		Baltim	ore							1 X Yes 2 No	
	다 5g 1	Ë	10e. Street and Number			10f. Zip	Code				10g. Citizen of	What Cour	ntry?	
	23a	a	3142 Sequoia Av	re			212	215			U.	S.A.		
	ama ama	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Deced	ent of His	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)		ace - Americ		
98	or it	by Funeral Director	1 Never Married 2 Married	1 ∐Yes 2∭∭ If Yes, Give	No	1 ☐ Yes 2		Specify:		,	Speci			
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ţ	mit. Pa partmen sortant: injury		`4 □Donation 5 □ Other (Specify	<u> </u>	Arbutus					2/9/05	Arbu	tus,	Md	
Baltimore,	permit. Pages to Department of Findortant: If Ite any injury or ot once.		21. Signature of Funeral Service Licer	2 /		22. Name and 1arch	F/H	Wes	st					
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):									
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ū		on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry y Year) 28b. Time Injury		Bc. Injury Work			3d. Describe h	ow injury occu	rred		
sio	Attanding ir death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 🗆 N						
Division	Il or Attand after death Diractor: /	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, larm, s c. <i>(Specify)</i>	treet, factory,	office		28	3f. Location (S City or Tow		ber or Rura	I Route Number,	
	ospital or A hours after unarat Dira ly filled in by													
	To the Hospital or within 24 hours afte To the Funaral Dir completaly filled in	Medical	(Check only 2 Madical Exan	ysician: To the best of niner: On the basis of	fexamination and/or i	ith occurred a nvestigation,	it the time in my opi	e, date and nion, deat	d place, an h occurred	nd due to the c d at the time, d	ause(s) and m late and place,	anner as st , and due to	ated. the cause(s)	
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	(2)		30. Name and address of person who	1) 1				31101			
			31 Date filed (Month Day Year)	/V/ U	25 Main	Ste K	PISTO	creten	×	MD	21136			
	Sta Registr		31. Date filed (Month, Day, Year) 7	2005	ar's Signature	A STATE OF THE PARTY OF THE PAR								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item#31, perbyr, C840 2/7/05 TT and Mental Hygiene 0 0 5 03433 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death 9:30AN JA N **Physician** /Medical 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 250-54-489 1 M 2 XF Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1XYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330C OAKFIGLD Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Nona HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be MELVIN SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7/20 19a. Informant's Name/Relationship (Type, Print) 3305 OAKFIELD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State ING HEMORIAL 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNCE H 21. Signature of Funeral Service Dicensee N. MONROE ST. 1721-27 MD ZIZIT 23a. Part: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one ceuse on each line. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last ATHEROSCUEROTIC CARDIOVASCULAR 15 Y85 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown HYPERCHOLESTERILEMIA Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner physician and s the bunal-trensi Division of Vital Records, P.O. Box 68760 n 24 hours efter des le Funerei Director bletely filled in by th To the Hosp within 24 hor To the Fune completely fi

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Evantinar must be notified at once.

altimore, Maryland 21215-0020

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 0018144

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person wire completed cause of death (Item 23a) (Type, Print)

DIV, CARDIOLOGY F. BALTAZAR, M.D. Sinai HOSPITAL

			1 - For State Registrar	State of Ma	arylan		artment o		and M		_	05	03434
7.	Physici	an	1. Decedent's Name (First, Middle, La: Cyrus F. Jones	st)						2. Date of Dea Month Januar	Day,	2 OOF	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	e street and number)			4b. City. To	wn, or Location	of Death	Januar		V of Death	4:56 PMM
	LAGIIII	g.	Avalon Manor Nu					rstown				shing	ton
是.	Funeral Director		5. Social Security Number 6. S 218-09-9495	ex 7. Ag XDM 2□F	e (In yrs. 88	last birthday) Yrs.	If Under 1 Months E	Year If Unde lays Hours	Min.	8. Date of Birth (Month, Day, Dec 12,	Year) 1916	9. Birthp Cour New	lace (State or Foreign try) York
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
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	vith th	Dire	10e. Street and Number	1			10f. Zip Co			1	0g. Citizen of	What Cour	itry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow amy pringry or other traumatic event, the Medical Examinar must be notified at ODGe.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ Note 1 Yes, Give Year or Dates:] .	f Yes, specify			ecify Yes or No- Rican, etc.)	Bla	ack, White.	etc.
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Baltimore,	Pages 1 Iment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	0	a	lace of Dispo emetery, cren	sition (Name in atory or othe	of r place)	D	ate	20c. Location	- City or To	wπ, State
Ball	Depart Depart Import any in		21. Signal to of Funeral Pervice Licen	CAORE		Ва	ltimor	e, MD	21201			ore S	treet
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<u>></u>	S S	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		ER/Outpatient	3 □ DOA	Other: 42N	ursing Hon	ne 5 Reside	nce 6 🗆 Oti	ner (Specity)
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<u>≥</u>	i i i e	Certification;	4 Homicide determined	building, etc	. (Specify)	eet, factory, or	rice		28f. Location (Str City or Town	State)	per or Hurai	Houte Number,
	To the Hospital within 24 hours a To the Funeral C completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at the estigation, in	ne time, date ai my opinion, dea	nd place, a ath occurre	and due to the ca	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)
	To th within To th compl	2	29b. Signature and title of certifier				29c. Li	cense number		29	d. Date signe	ed (Month, L	Day, Year)
			1 tain	muchen			D	0060	> 39	16	01/2	8/01	2
		ļ,	30. Name and address of person who of FARID M	completed cause of de	eath (Item	23a) (Type, F	Print) 1/2	6 01	al	()	Hagi	15	220
	Sta	to.	31. Date filed (Month, Day, Year)	324Registra	r's Signat	III'A				1	ND	31	40
ile:	Registr		FEB 0 7 200	27	J 10	do	at I						

Jenkins, Mary

		1	1 - For Stete Registrar	State of Mar	ryland / Depa <i>Cer</i>	artment of rtificate of			iene	03435
	Physici	an	1. Decedent's Name (First, Middle, Last, Mary Ingersoll J					2. Date of Dear	y ^{Day} 7, 2005	3. Time of Death 5:00 PMM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	Januar	4c. County of Deatl	
			Mariner Health o			Laure			Prince G	
	Funeral Director		5. Social Security NumberUNK 6. Se	7 44 670 5	(In yrs. last birthday) 94 Yrs.	Months Days		8. Date of Birth (Month, Day, Oct 14		nplace (State or Foreign untry) inois
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo			1 000 14	, 1010 111	
	Maryla f shot	jo	MD Montgome		•	er Sprin	.g			10d. Inside City Limits 1 ☐ Yes 2√2 No
	h the l	Irect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	
	ath wit	ralD	10306 Parkman Roa				20903		USA	
036	urs after de el', or items Exercili et n	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "naturel", or items 23a or 28a-f show says injury or other traumatic event, Ira Mudical Exerciti at must be multical and once.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	(e completed) College (1-4or 5+)	(Give life. L		ed) during most of work	ing	16b. Kind of Business/I	industry
i Q	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	5+	h	omemakeı	18. Mother's Nam	e (First, Middle, I	OWn h	ome
lan'	Aental Aental rked c	To Be	Daniel Winthrop	Ingersol1			Emma	Kipling	Hess	
lary	2 sho		19a. Informant's Name/Relationship (T)		1	-			, City or Town, State, Z	(ip Code)
e,	1 and Health tem 27		Susuan Shawhan/dau	ignter	20b. Place of Dispo	sition (Name of		-	ing MD 2	0903 Town, State
ē	Pages lent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ※ Donation 5 ☐ Other (Specify)		cemetery, cren	natory`or other pl	ace) 			
Baltimore,	permit. Departm Importa eny inju		21. Signa use of Euneral Service Licens	Wade Vire	gtor St	Name and Add Late Ana lltimore	tomy Board MD 2120	1 ₁ 655 W.	Baltimore	Street
8760,	Physician and business and street be executed by the purial-transit street	al Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a b. Due to (or as a c.	consequence of):		,		est,	Approximate Interval Between Onset and Death
P.O. Box 687	the death certif by the attending ached for use a	by Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3 me of death 5	Ectopic pregnan Other (specify)			23d. Date of delifing Month	Day Year
	w requires that the been signed by the should be detache		Part II. Other significant conditions co		not resulting in the u	nderlying cause g	iven in Part I.		oacco use contribute to es 2 □ No 3 □ Pro	
Division of Vital Records,	e law has b	Completed						24a. Was a autops perforr	n 24b. Were aug y prior to death?	topsy findings available completion of cause of
/ital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)	
ion of	ding Phys h. After this funeral di	atlon: To	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatien 28b. Time of Injury	28c. Inj			ence 6 Other (Spec ow injury occurred	erfy)
Divis	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y · At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	Hospital 24 hours a Funerel i	edical	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the best of iner: On the basis of e and manner state	examination and/or in	n occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and marrier state		29c. Licer	nse number	2	9d. Date signed (Month	n, Day, Year)
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			30. Name and address of person who		ath (Item 23a) (Type,		AHDIT	11/2 3	のマハブ	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	THE L	MUKEL	The L	0101	
	Regist	- 1	31. Date filed (Month, Day, Year) FEB 0 7 2005	Aloesa	I GOOM	N. C. C. C. C. C. C. C. C. C. C. C. C. C.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Gertrude S. Johnson 29 2005 /Medical January 10:30AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Nursing & Rehab Annapolis Anne Arunde1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 82 214-12-3831 Director May 9 Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Evandron must be notified at 1 TYes 2 □ No Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 Second St. 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXXNo If Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Be Completed by 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than College (1-4or 5+) 8th Domestic 0 Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Horace Sembly Mary Alice Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renea D. Johnson(Daughter) 2) 420 Second St. Annapolis, Md. 21403 20b. Place of Disposition (Name of Besseley, a tree on Meliterical al 2-4-05 Annapolis, Md. other 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 2-4-05 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Zavry B. Heese Moo 483 | 821 West St. Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 **Physician** Immediate Cause (Final disease or condition resulting in death) ASTERIOS CIEROTIC CAMDIOVARULA /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) page 2 should be deteched Part # Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) QUEENS BUNG Rd 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 7 2005 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month **Physician** 2005 11:15 A Jan Garrison Edward Kilson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hartford Nursing Home Harbor side Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 120 M 2□F Months Days Hours Director 28,1930 Maryland 220-26-3110 74 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b, County 10d. Inside City Limits show "natural", or itams 23a or 28a-f show 1 ☐ Yes 2 No Completed by Funeral Director Centreville Maryland Queen Annes 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 USA 200 Clabber Hill Road death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced **Black** th and Mental Hygiene.

7 is marked other than "natur traumatic evant, I'm Mydlow 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Hill Lumber Co. Truck Loader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ William Kilson Blanche Cheers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in item 27 i 21984 Lovers Lane, Rock Hall, Maryland 21661 Patricia Williams / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Mt. Vernon Church Cem 02-02-05 Centreville, Maryland 21. Signature of Funeral 897 ^{22. Name and Address of Facility}
Bennie Smith Funeral Home
Road 298, Chestertown, Maryland 21620 runce 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Progressive Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit The law requires that the death certificate be executed Cercon vom attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Dialete Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No μĐ 9 Unknown 9 Unknown ۵ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has be inector, page 2 s 2 No 1 Yes Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 310 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 20 D31464 elban 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soute 308, Bull, MD 21201 SHOAIIS 821 N. EUTAW H43/241 31. Date filed (Month PDB) 32. Palstrar's Signature State Registrar

DHMH 17 Rev 1/2001

	2		1- State Amend Item 2	State of Ma 29c,30 pe	aryland (02 /0	artmen 1,05d tincati	t of H	ealth a	and Me	ental Hyg	jiene	005	_021.20
	Physici	an	Decedent's Name (First, Middle, Last) Til							1	2. Date of Dea Month	Dav	Year	3:-Time of Death U
	/Medio	al	Florence C. Kran				4h City	Town or	Location of	of Death	Januar		2005 unity of Death	1:00 AMM
ı	Examir	er	Charlestown Ret:				,		ville			1	altimo:	
	Funeral		Social Security Number 6. Sex		je (In yrs. last	birthday)	If Under		If Under		B. Date of Birth	1	9. Birth	place (State or Foreign
L	Director		074-30-1762	M 2∭ F	101	Yrs.	Months	Days	Hours	Min.	(Month, Day May 17	, 190		intry) inois
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	Maryl -f sho lied a	į	MD Baltimon	re		Cat	onsvi	11e						1 □Yes 2X No
	r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	intry?
	th with	alD	709 Maiden Choice	Lane				21	228				USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic evant, the Modical Examble must be mailied at ODGE.	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1 ☐ Yes 2				ify Yes or No- ican, etc.)		Race - Amer Black, White Dec <i>ify:</i> whi	, etc.
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ַק	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name (First, Middle,	<i>Maiden</i> Su	ımame)	
Ja	Menta Menta Irkad Itic ev	ToE	George W. Coulter						5	Sarah	Jane B	eggs		
lan	2 sho and Is me		19a. Informant's Name/Relationship (Type								Route Numbe			p Code)
2 ∂`	l and fealth im 27 her tr		Theresa Ottery/fr:	lend			4 Tri.		hia F	Road I	Ellicot		•	21042
Baltimore,	Pages I ment of H ant: If ita	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☒ Donation 5 ☐ Other (Specify)	_/	7	etery, cren	natory or o	ther place	9)	Da	18	20c. Local	tion - City or T	own, State
Ball	permit Depart Import any in		muny	1000	EUE	St Ba	TUTLIC	natore,	omy B MD	oard 21201	655 W.		imore	Street
ì	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused te cause on each ling.	the death. D					cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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O. Box 6	death certif e attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3□]€ctopic pre] Other <i>(sp</i> e					230	I. Date of deliv Month	ery Day Year
ς. J	quires that the n signed by th uld be detache	d by Pr	Part II. Other significant conditions con Stage III D	tributing to death b	out not resultin	ig in the ur	nderlying ca	ause give	n in Part I.			bacco use		the cause of death?
Hecord	The law requires ate has been sign page 2 should be	Completed	Anorexia		-						24a. Was a autops perform	med?	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
Vital		Be C	25. Was case referred to medical examiner?						26. Place	of Death (Check only or			
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DIX	tal or Attanors after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, cc. (Specify)	, farm, str	eet, factory	, office		28	f. Location (Si City or Town		lumber or Rur	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Exemination	sician: To the best ner: On the basis o and manner sta	f examination	dge, death and/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, an th occurred	d due to the c at the time, d	ause(s) an ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c	License	number		2	9d. Date s	igned (Month,	Day, Year)
			Deven B	enlin	1 km	2	Ð	دېپ	7303			1/30	105	
			30. Name and address of person who con				,							
	- 01		Deneen Bowlin, M 31. Date filed (Month, Day, Year)		estown ar's Signature		remen	t Ce	nter					
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amend item//, per MD, G840, 2/7-05 The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Joseph Lindsey **Physician** Month Day Year Sac ohn 9:05 A. M JANUARY 29, /Medical 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 578-20-5130 Yrs. 81 AUG 8, 1923 WASHINGTON D.C Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 27 Is marked other than "netural", or Items 23a or 28a-f show treumatic event, the Medical Exercities matter notified at 10d. Inside City Limits MARYLAND Directo BALTIMORE TIMONIUM 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 533 WYNGATE ROAD 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours efter of Health and Mental Hygiene. Item 27 le marked other than "netural" or Item 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 12 POSTAL CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OPIE LINDSAY CLARA ANN WANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT E. MILLER / NEPHEW 1825 JUDICIAL WAY, CROFTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any Injury or otl 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2/5/2005 Huntt Crematory Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, Sol 1. Kmi 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit that initiated events the attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ stak 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 100 1 Inpatient ۵ 2 ER/Outpatient 3 DOA this 27 Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 53041 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GAAN EMANLIE JAN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1XM 2□F 577-38-3986 Yrs Director 72 Dec 9, Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "neturel", or Items 23e or 28a-f show 10a. State 10b. County 10c. City, Town or Location rthan "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Be Completed by Funeral Director MD Howard Columbia 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 7131 Winter Rose Path 21045 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give 150-62 Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 inventor self employed other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emanuel Lee Logan Sr ပ္ Cassie mae Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Logan/spouse 7131 Winter Rose Path Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 Department o Important: If any injury or once. 21. Signature of Funeral Se ice dicensee de. Director State and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TOCARDIAL Physician disease or condition resulting in death) /Medical Examiner ATZD LOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Certification: To Be Completed by Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit BILMERAL that initiated events resulting in death) Last Due to (or as a consequence of): PSIS P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 □ Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, わししたモ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann 1 Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours af
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completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie eted cause of death (Item 23a) (Type, Print) 801 32. Registrar's Signature State 2005 Registrar

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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	age D	irector	ŝ	2 Name an	d Addres	s of Facility	oard	655 W.	Baltim	ore	Street	
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Med	29b. Signature and title of certifier	and mai	nner stated.		290	c. License	number		25	9d. Date sign	ed (Mont	h, Day, Year)	-
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			30. Name and address of person who	completed cau	ise of death (Ite	5 L I	A 1	. 1/	CD -	1	2 10	0 1	U	1 21222	_
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 05 03442 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician 1:20 A Joanne E. Magez 27,05 4c. County of Death /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Joseph Richie Hospice n/a Baltimore
| If Under 1 Year |
| Months | Days | Hours Min. May 9, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 250F 54 Director 218-58-5755 Marylánd Usual Residence of Decedent t and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Ever cliner must be notified at 10b. County 10d. Inside City Limits MD n/a XXYes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 COlchester Rd. 21229 Apt. 166 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 2≧No Specify:White Specify: White 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jim E. Hodges Jr. 2 <u>Alma Wallnofer</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Charles William Magez- Husband 4001 Colchester Rd. Apt. 166 Baltimore, MD 21229 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of commetery, crematory or other place)
Baltimore Crematory
Loudon Park Date 20c. Location - City or Town, State Pages 1 *4 ☐ Donation 5 ☐ Other (Specify) Jan. 28, 05 Baltimore City 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner shtonenh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner W 40515 that initiated events resulting in death) Last Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 / No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 1 Tes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA o the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Thomicide 1 Gentrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

(OBIE)ZT

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death McMillan Month Day Ethel **Physician** County of geath 3.24 pm 2,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Baltimore MORE If Under 24 Hrs. 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Yrs. 5. Social Security Number 9. Birthplace (State or Foreign Funeral Days N. Caplina 216-36-8199 1 M 2 F Months Director Usual Residence of Decedent 10c. City, Town or Log 10d. Inside City Limits 10a. State 10b. Count 7 is marked other then "naturel", or Items 23e or 28e-1 show treumatic event, it a Madical Examiner must be notified at 1 Tes 2 No Completed by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Morgan State Univ Elementary/Secondary (0-12) College (1-4or 5+) Custodian 1 and 2 should be filed with Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Widdle, Maiden Sumame) Be Ada Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 3406 W. Rogers Are. Battimbre, Maryl. Marylan Gamble-son Department of Health importent: if item 27 20b. Place of Disposition (Name of U 20a. Method of Disposition State permit. Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Furgeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 60 disease or condition resulting in death) strointest /Medical Due to (or as a consequence of): Examiner vertic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 98 attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27. Man of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 2, 2005

State Registrar 31. Date filed (Monti

Memillan

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Known

30. Name and address of person who completer cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Physici /Medi			lack, Jr			2. Date of Death Month	Day Year	5 04 319
Examir Funeral	ner	4a. Facility Name (If not institution, give street a 5. Social Security Number 6. Sex	h Care 7. Age (In yrs. last birtho	Batti			4c. County of De	ath irthplace (State or Fort Country), UISIANA
Director		385-34-0216 1X M 25 Usual Residence of Decedent	F 69 68 Yrs	s. Months Days	Hours Min.	Feb 24,	1936 Lo	uisiana
fe Lai	ŗo	10a. State 10b. County MD	10c. City, Town o	r Location timore			<u> </u>	10d. Inside City Lin
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if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	Funeral Director	22 S. Athol Avenue 11. Marital Status 12. Was Arm	s Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cui	21229 Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Arr Black, Wh	
tural', or ite al Evamine	Ď	If You	Yes 2X)Ño es, Giv <i>e</i> ur or Dates:	1 ☐ Yes 2X No			Specify:	black
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dygien har th nt, the		9 17. Father's Name (First, Middle, Last)	0 jac	k hammer o	1	- /Ci Middle Mai	pav	ing
and Mental Hygiene. Is marked other than sumatic event, the Ms	To Be	J.C. Mack Sr			Mary Mac		,	- L
aith and 27 is m ar traum		19a beformant's Name/Figlationship (Type, Prin Kattie Wells Kathy Wells/niece		ailing Address (Stree 24 Lynview				Zip Code)
Department of Health in Important: if Item 27 is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal 1 □ Donation 5 ☒ Other (Specify) in	from State 20b. Place of Di cemetery, State	isposition (Name of crematory or other pla			c. Location - City o	r Town, State
Depart Import any inj		21. Signature of Funeral Service Licensee Ronald S. Wade	, Director	State Ana Baltimore	ess of Facility Lomy Board MD 2120	I 655 W. В	altimore	Street
Sician and Medical caminer	at Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of):	Infac				Approximate interval Between Onset and Deat
been signed by the attending physician should be detached for use as the buria	Physician/Medical	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnand 5 □ Other (specify) _	.y		23d. Date of de Month	blivery Day Year
n signed Id be det	þ	Part II. Other significant conditions contributin	g to death but not resulting in th	e underlying cause gi	ven in Part I.	23e. Did tobace		to the cause of death Probably 4 Unkn
ate has page 2	Completed					24a. Was an autopsy performed	prior to death?	utopsy findings avail completion of cause s 2 \(\text{No} \)
fter this neral di	ation; To Be	1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☑ ER/Outpa Date of Injury (Month, Day Year) 28b. Tim Injur	e of 28c. Inju	her: 4 🗆 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how in		acify)
s after do	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Street City or Town, St	t and Number or F tate)	Rural Route Number,
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai ((Check only 2 Medical Examiner: On	To the best of my knowledge, do the basis of examination and/od manner stated.	eath occurred at the tr r investigation, in my	me, date and place, opinion, death occurr	and due to the cause red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
withir To th comp	Me	29b. Signature and title of certifier	mD	29c. Licen	se number		Date signed (Mon	
		30. Name an ddress of pers in who completed					,	

	-		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005	45
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) HATTIE VAE MONTGOMERY 4a. Facility Name (If not institution, give street and number) Tender Care Castle 2. Date of Death Month Day Year 03 2005 8:45 4b. City, Town, or Location of Death Baltimore	path A
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 79 1 M 2 F 79 1 M 2 M F 79 1 M 3 M	
	the Marylar r 28a-f show	rector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City L Maryland Baltimore 10g. Citizen of What Country?	
980	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinations in	by Funeral Director	3901 Garrison Blvd. 21215 U.S.A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Ves Company No Specify Cuban, Mexican, Puerlo Rican, etc.) 1 Ves 2 No Specify: Black	
21215-0036	2 should be filed within 72 hours after dea and Mental Hygiene Is marked other than "naturel", or Items aumatic event, the Medical Exameneria	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Housekeeping	
Maryland	should be fill nd Mental Hy i marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Juanita Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trau <u>once</u> .		Lavern Lowery / Daughter 20a. Method of Disposition 1 \(\mathbb{R} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Removal from State 1 \(\mathbb{R} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 \(\mathbb{D} \) Donation 5 \(\mathbb{O}\) Other (Specify) 20c. Location - City or Town, State 20d. Method of Disposition 4 \(\mathbb{D} \) Donation 5 \(\mathbb{O}\) Other (Specify) 3 Carrison Forest Ceme \(\mathbb{O} \) 2/10/2005 \(\mathbb{O}\) Owings Mills, Maryla 21. Since ture of Funeral Service Licenses 22. Name and Address of Facility The Derrick C. Jones F/H, P.A	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 4611 Park Hgts. Ave., Baltimore, Maryland 212 Approximate Interval Between Conset and Death Cardinal Cause (Final disease or condition resulting in death)	en
8760,	sate be executed shysician and the burial-transit	al Examiner	Sequentially list conditions, in any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	r
Records, P.	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Donkn	
Vital Reco	on: The law r ilicate has be or, page 2 sh	e Completed	24a. Was an autopsy findings avail prior to completion of cause death? 25. Was case referred to medical 26. Place of Death (Charle and Local)	lable e of
Division of Vi	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To B	examiner? 1	
Divi	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifier (Check only (Check	
	To the Howithin 24 To the Fu	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	4		Jasueu Lollian D28585 2/3/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNETM CAKHANI, 7220 PARK HEIGHTS AVE, BALD MD	21208
	Sta Regist		31. Date filed (Month, Day, Year) 32 registrar's signature	

									Mental Hygi	•	
			1 - Stete Registrar			Cei	tificate of	Death	Res	g. No. UU	03446
ı	Physici	an	Decedent's Name (First, Middle, La	,					2. Date of Death Month		3. Time of Death ear
	/Medic	al	Sherry Lang No. 4a. Fecility Name (If not institution, give				th City Town	-1-26 (8	Feb.		
	Examir	er	Gilchrist Center		*	re		or Location of Dea WSON	ith	4c. County of	altimore
	Funeral		5. Social Security Number 6. S			last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		. Birthplace (State or Foreign
	Director		212-01-02-0	□ M 2 X F	42	Yrs.	Months Days	Hours Mir	8. Date of Birth June 10	962 M	aryland
	pun 🔏		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y. Town or Lo	cation				10d leade Chatter
	Aaryla F sho	or		1							10d. Inside City Limits 1 ☐ Yes 2 No
	28a-	Directo	Maryland Carrol 10e. Street and Number	,i.	ria	nchest	10f. Zip Code		100	g. Citizen of Wha	
	3a or	IDI	2690 Bert Fowl	er Rd.				1102		U.S.	
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. \	1		Specify Yes or No- rto Rican, etc.)	14. Race -	American Indian,
٥	after or Ita	/ Fu	1 Never Married 2 Married	1 Tes 2			r res, specify Cut		no Rican, etc.)		White, etc.
3	urel',	d by	3 Widowed 4 Divorced	Year or Date	es:					Specify:	White
9500-61212	be filed within 72 hours after death with the Maryland that Hygiene. ad other then "naturel", or itams 23a or 28a-f show avant, the Medical Exerting or usit to notified at	Completed	15. Decedent's E (Specify only highest gra	ide completed)		16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during most of world)	orking	3b. Kind of Busin	iess/Industry
7	iene.	отр	Elementary/Secondary (0-12)	College (1-4	or 5+)			epresent		isa Int	ernational
	il Hyg othai	Be C	17. Father's Name (First, Middle, Last)		1		1	ame (First, Middle, Ma		
yland	uld be Menta rrkad ritic av	To B	Ervin M. Lang					Janet	Miller		
Mar	2 should be f and Mental F Is marked of reumetic avair		19a. Informant's Name/Relationship (Rural Route Number, (
	l and sealth m 27 har tr		Terry W. Nowlin -	husband	205 5	A STATE OF THE STA		ler Rd.	Manchester		
baltimore,	Pages 1 nent of F int: If ite iry or ot		20a. Method of Disposition 1		C	emetery, cren	sition (Name of natory or other pla k Church	Cem. Fe	Date 2005		y or Town, State
gall	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic angres.		21. Signature of Funeral Service Lice	nsee J		Ec.	Name and Addr Shardt F	ess of Facility uneral Cl	hapel P.A.	Md 21	102
F			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the deat						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Cold				UTI PURC			Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or	as a conseq						
	Examine		Sequentially list conditions, if any, leading to immediate	b							ļ. <u></u>
,	ted	Examiner	rd any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence ot):					,
✓ _^	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):					
8/00,		call		d							
٥	certificate Iding phys	_								-	
X D	th cer tendir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pregnanc	:v		23d. Date o	-
	e death the atten	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknow	4☐Pregnan 9☐ Unknow	t at time of d		Other (specify)	,		Month	Day Year
ĭ	hat th ad by detacl		Part II. Other significant conditions of	ontributing to deat	h but not resi	ulting in the ur	nderlying cause gr	ven in Part I	23e Did toba	cco use contribu	te to the cause of death?
as,	w requires that the death certifica been signed by the attending ph should be detached for use as th	d by					idonying badoo gi	VOIT ATT LATE 1.	1 ☐ Yes	1.	Probably 4 Unknown
000	w requ been shoul	lete							24a. Was an	24h Wor	e autopsy findings available
Ĭ.	: The law cate has b	ompleted							autopsy performe	prior	to completion of cause of th?
VIII	icien: Th	e C	25. Was case referred to medical					26. Place of De	ath (Check only one)	No 1 🗆	Yes 2 No
	Physicien: this certificial director,	To B	examiner? 1 🗌 Yes 2 💯 No	Hospital: 1 🗌 Inp	atient 2 🗆	ER/Outpatien	t 3□ DOA Ot		Home 5 Resident	ce 6 Dother (Specify NOSOLO
0 [ding Phys h. After this funeral dir		27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	28c. Inju		28d. Describe how	injury occurred	
SION	Attending at death. actor: After by the funer	catl	2 Accident Investigatio					Yes 2 No			
<u> </u>	after of Dirac	ertification;	4 Homicide determined	289. Place of	, etc. (Specify	me, tarm, stre	eet, factory, office		City or Town,	et and Number o State)	r Rural Route Number,
	spita nours naral	0	29a. Certifier 1 Certifying Pr	ysicien: To the be	est of my kno	wledge, death	occurred at the ti	me, date and plan	e, and due to the cau	se(s) and manne	r as stated.
)	To the Hospital or Attending F within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer.	edical	(Check only 2 Medical Exer	niner: On the basi and manner	s of examina	tion and/or inv	estigation, in my	opinion, death occ	urred at the time, date	and place, and	due to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier)			29c. Licen	se number			fonth, Day, Year)
			Man	Nino			250	5 20 5	H	Brussy	4 2005
	1.		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I	Print)	. A .	1.03.0-		
	0		AAron Charles W	30 000	istrar's Signs	tura le	3 34 13	outruse	MD ZIZEY		
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 0 7 2	2005	Euro J	ture	and I				
			1			-	-				

				For State Registrar	State o	f Maryla	and / Depa <i>Cel</i>	artment of H	lealth and M Death		EME 005	03447
		Physici	20	1. Decedent's Name (First, Middle,	Last)					Date of Death Month	Day Year	3. Time of Death
		/Medic		MARY ELIZABETH						JANUARY	30, 2005	9:55p ^M
	1	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or BALTI	Location of Death		4c. County of Deat N/A	h
		Funeral		JOSEPH RITCHIE 5. Social Security Number 6	. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
		Director		214-14-3628	1□M 2□F	89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) 3-20-19	(ear) Co L5 MAR	untry) YLAND
		pur 🕻		Usual Residence of Decedent 10a, State 10b, County		100	City, Town or Lo	cation				10d. Inside City Limits
		Aaryla F shor	ō									1. Yes 2 No
		28a-	Director	MD N/A			BALTIMOF	10f. Zip Code		100	g. Citizen of What Co	untry?
		h with		2143 N. POLASK	I ST.			2121	7		USA	
		ams	Funeral	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	36	s afte		1 Never Married 2 Married	1 ☐ Yes If Yes, Giv Year or D	2 ፟፟፟፝ No ∕e	ľ	1 ☐ Yes 2 🗓 No	Specify:		Specify: BLA	
	8	tural	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's		ates:	16a, Dece	dent's Usual Occupa	ation	16	6b. Kind of Business/	ndustry
	215	hin 72 3. Media	plet	(Specify only highest s Elementary/Secondary (0-12)	grade completed) College (1	I-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki	ing		,
	21	ed wit	Completed by	-12-	-0-		SEA	MSTRESS			TAILOR	
	Maryland 21215-0036	be fill Hy ad oth	Be	17. Father's Name (First, Middle, La	·				18. Mother's Name		uiden Sumame)	
	ĭ <u>ĕ</u>	hould d Mer marks matic	To	JAMES LAWRENCE 19a. Informant's Name/Relationship			19h Mailir	Address (Street	NELLIE V		City or Town, State, 2	in Code)
	Ma	nd 2 s lith an 27 is r trau		JAMES MASON(SC							, MARYLAND	
	Je,	of Heal		20a. Method of Disposition			. Place of Dispo cemetery, crer	sition (Name of natory or other place	e) C	Date 20	c. Location - City or	Town, State
	Ē	Page ment c ant: If ury or		1 Marial 2 dremation 3 dremation 3 dremation 3 dremation 5 dremation 5 dremation 3 dremat	cify)	Al	RBUTUS M	EMORIAL 1	PARK 2-4-		ALTIMORE,	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21st marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exercited mental be redifficed at once.		21. Signature of Funeral Service Lie	JONAT	HAN D	.5 = 1.7					, P.A. LAND 21217
				23a. Part1. Enjer the disease, or co shock, or heart failure. List on	mplications that only one cause on e	aused the deach line.	eath. Do not ent	er the mode of dyin	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between
40		riysician		Immediate Cause (Final disease or condition resulting in death)	_ a Î	M	NAC	ance	1			Onset and Death
1-5		/Medical Examiner		resulting in deathy	Due to	(or as a cons	equation of):					
SS			er	Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury	b. Due to	or as a cons	equence of):					
0		cuted	Examiner	Cause (Disease or injury that initiated events	c.							
	oʻ	ate be executed hysician and the burial-transit		resulting in death) Last	Due to	or as a cons	equence of):	_				
10	8760	ate by s	dical		d							
13	9 xo	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pre	gnancy				23d. Date of deli	ven/
10	B.	death a atter d for u	iciar	in the past 12 months?	4□Pregn	irth 2□F ant at time c		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
-	P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unkno							
	S,	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to de	eath but not i	resulting in the u	nderlying cause give	en in Part I.	4 2-1	cco use contribute to	
V	ord	requii	eted	CVITOTVIC	100 00	V UTC	100	11 VCOVV	CON GOLY	10 Yes		babiy 4 Unknown
F	Records,	ne law has t je 2 s	Completed	009	1200 IR-					24a. Was an autopsy performe	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
/ewis			e Co	25. Was case referred to medical					00 Bl	1 Yes 2]No 1 □ Yes	2 No
3	of Vital	Physician: rthis certific ral director,	0 8	examiner?	Hospital:	npatient 2	☐ ER/Outpatier	t 3 DOA Othe	26. Place of Death	n (<i>Cneck only one)</i> me 5 ☐ Residenc	ce A Other (Spec	m Hosma
Š		두 등 등	n: T	27. Manner of Death 1 □ Natural 5 □ Pending		of Injury th, Day Year,		28c. Injury Work		28d. Describe how		37 1 10 2 1
~	Sior	Attendir death. ctor: Af y the fu	catic	2 Accident investigat	ion			M 10'	Yes 2□No			
Jary	Division	or Attend after death Diractor: /	Certification:	3 Suicide 6 Could not determine	288. Place	of Injury · A ng, etc. (Spe	t home, farm, str cify)	eet, factory, office	2	28f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
'S'		spital ours a neral (29a. Certifier Certifying	Physician: To the	best of my k	nowledge, death	occurred at the tim	e date and place a	and due to the caus	se(s) and manner as	stated
0		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	ledical	(Check only 2 Medical Ex	aminer: On the ba	asis of exam ner stated.	nation and/or in	estigation, in my op	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
		To the comp	M	29b. Signature and title of certifier	1001	11	\wedge	29c. License	number	29d	. Date signed (Month	, Day, Year)
	}			- Club	LLXLLI	MI		1)	1000	0	1/01/0)
4		Ä		30. Name and address of person wh	d completed caus	e of death (I	tem 23a) (Type	Print)	lo St	Ball	inner	11)21287
		Sta	te	31. Date filed (Month, Day, Year)	32. R	es strar's Sig	nature	1		0000	-	
	1	Registr	ar	FEB 07	2005	lighten.	S. K	portes				

			State of Maryland / Depar		•	9
			For State Registrar Certi 1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. I	10.2005 03448
	Physici		Veldon Lee Parham			Day Year 12:05 Am
	/Medio Examin			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N / A
	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1 2 / 0 4 / 1 9	
	72 hours after death with the Maryland natural', or items 23s or 28s-1 show Jical Exault wr must be notified at	2	10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits 1 ☐ Yes 2 XNo
	ter death with the Marylan Items 23a or 28a-f show I'ver must be notified at	Director	MD BALTIMORE ESSEX 10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
	23a o		1000 FRANKLIN AVENUE APT 1007	21221		JSA
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces?	as Decedent of Hispanic Origin? (Spi res, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9036	72 hours aft natural, or Jical Eva	þ	1 ☐ Never Married	Yes 2 No Specify:		Specify: BLACK
215-(within 72 hours after sne. than "natural", or i whe Jical Ever i in	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation nd of work done during most of work ONOT use retired)	ing 16b.	Kind of Business/Industry
212	D O =		12TH			
Maryland 21215-0036	a la la	To Be	17. Father's Name (First, Middle, Last) ROBERT LEE PARHAM	ALMA	M. WILK	INS
Mary	Par se and	•	19a. Informant's Name/Relationship (Type, Print) ANNA PARHAM / WIFE 1000	Address (Street and Number or Rura FRANKLIN AVE,	A PT 1 (y or Town, State, Zip Code) 21221
ore,	ges 1 and 3 of Health if Item 27 or other tr		20a. Method of Disposition 20b. Place of Disposit	tion (Name of trong or other place)	Date 20c.	Location - City or Town, State
Baltimore,	Pa In the		*4 Donation 5 Other (Specify) GARRISON	VET CEM 02/1 FOREST	1/05 OF	VINGS MILLS, MD
Bal	permit. Departr Imports any inju		~ 20	Name and Address of Facility HC	WELL FUN	WERAL HOME 21207
			23a. fant / Enter the disease, or complications that caused the death. Do not enter shock, or leart failure. List only a support on each line.	the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	resulting in death)	Phageal Can	cer	Onset and Death
	Examiner		Due to (or as a consequence of): Sequentially list conditions			
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury			
0,	be executed sician and burial-transit	Exar	that initiated events c. Due to (or as a consequence of):			
68760,	5 × 6	dical	d			
Box 6	death certificat e attending phy id for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant in the cost 12 growths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of delivery
o.	0 0	Physician/Med		Other (specify)		Month Day Year
<u>α</u>	es tha	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		o use contribute to the cause of death?
Records,	w requir been si should	leted			1 ☐ Yes 24a. Was an	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
l Re		Completed			autopsy performed	prior to completion of cause of death?
Vital	sician: certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death	Check onlone	
of	ding Phys h. After this funeral di	n: To	27. Mann r of Death 28a. Date of Injury 28b. Time of		me 5 Residence 28d. Describe how in	
Division	Attending r death. ector: After by the funer	ertification;	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Divi	al or At s after o	Certifi	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigated.	occurred at the time, date and place, stigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
)	T W T S E	M	29b. Signature and title of certifier 2. Will II M.D.	29c. License number DY 13 65	Eeb.	Date signed (Month, Day, Year) yu e.vy 5, 2005
	M		Jessy C. W. M. M. M. D. 30. Name and address of person who completed cause of death (Hem 23a) (Type, Pr CED VOL E. W. L. K. M. M. D. 3900 L. 21. Data filed (Month Day York)	och Raven Boul	evard, Bo	Himore, MD. 21218
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		1	
	ricgisti	er.	EED A 7 2005 Mars M	Assel)		

DHMH 17 Rev 1/2001

ORIGINAL ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. - U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Parks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death & 4c. County of Death **Examiner** Stella Maris Hospice at Mercy Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 🕱 F Director 216-12-3253 31, 1913 Virginia Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at Maryland N/A Baltimore Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23s 1200 Gylndon Avenue 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ Specify. White 3 Widowed 4 □ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer Box Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Selby Lucy Parkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: If item 27 is any injury or other tre Gale Smith (Daughter) 1200 Glyndon Avenue, Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery | 2/2/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Denti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) discusa atheroscleration **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 2 No 1 Yes 2 No Division of Vital 1 ☐ Yes the Hospitel or Attending Physiclen: director Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PIC Hospital: ပ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation within 24 hours after deam.
To the Funerel Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

3 State

Registra

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301

Registrar's ignature

29c. License number

140854

Ph Baldimore

29d. Date signed (Month, Day, Year) 31-05

			1 - For State Registrar	State of Maryla	nd / Depa	artment			-	05	03450
Е	Physici	an	Decedent's Name (First, Middle, Last)	25.64	DUDY			2. Date of De Month		Year	3. Time of Death
	/Medic		EVELYN 4a. Facility Name (If not institution, give s	JEAN	PURV		own, or Location	FEBRUAI	RY 3, 20	JU5	5:30 A M
	Examin	ier	2304 OVERBROOK DI			4b. City, 10		WINDSOR	4c. Count	or Death	CARROLL
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1	Year If Under	24 Hrs. 8. Date of Bir	h W Year)	9. Birth	place (State or Foreign
	Director		210-30-3077	IM 2₹ 6	S Yrs.	Months	Days Hours	Min. (Month, Da	1939	Cou	MD MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation			,		10d. Inside City Limits
	Maryl f eho	ō		RROLL		WINDSO	IR				1 ☐ Yes 2 ☑ No
	r 28a	rec	10e. Street and Number	KKOLL	NEN	10f. Zip C			10g. Citizen of	What Cou	ntry?
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show oral Examinar must be notified at	Funeral Director	2304 OVERBROOK D	RIVE			217	76			USA
	ems ems	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decede	nt of Hispanic Or	igin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Ra	e - Ameri ck, White,	can Indian,
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		Yes 2			Specil		WHITE
Ö	hour tural'	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		lent's Usual					
<u>.</u>	in 72 n "na nedic	piet	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	done durina mos	at of working	16b. Kind of B	usiness/in	dustry
21215-0036	filed within Hygiene. Ither than " int, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ARTI	ST			ARTIST	RY	
힏		Bec	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (First, Middle,	Maiden Sumar	ne)	
<u>X</u>	should be and Mental e marked aumatic eve	2	SAMUEL		SHIF	FMAN	AN	N			FLAX
Maryland	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		19a. Informant's Name/Relationship (Type	,				er or Rural Route Numbe			
	s 1 and f Health item 27 other t	1	PAUL PURVIS / HU 20a. Method of Disposition		23U4 Place of Dispo			IVE - NEW W			
Baltimore,	00-		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	natory or oth	er place)		20c. Location		
틒	permit. Pag Department Important: I any injury o		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 				.NS CEM	02/04/2005			
Ba	Department any i		Depth 1.	uttle				SOL LEVIN			
			23a. Part1. Enter the disease, or compli	cations that caused the dea				OWN ROAD - I		LE,	Approximate
	hysician		shock, or heart failure. List only on Immediate Cause (Final		rniatio	m					Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a conse			10			-	
	Examiner		Sequentially list conditions h	armery	centra	el new	9U3 545	eun lymphon	na	1	Four Months
	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Die to (or as a confie	quence of):		1	7.1		-	
	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	be executed siclan and burial-transit		Totaling in down, Edot	Due to (or as a conse	quence of):						
387	physi s the t	Physician/Medical	d								
Box 6	death certifica attending ph of or use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr	nancy				23d Da	te of delive	any
ă	death a atter d for u	clar	in the past 12 months?	1☐Live birth 2☐Fet 4☐Pregnant at time of		lEctopic preg Other (spec				nth	Day Year
o.	that the de led by the detached	hysi	9 Unknown	9□ Unknown							
ď.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cau	se given in Part I	. 23e. Did to	bacco use con	ribute to t	he cause of death?
Records,	w require been sig should b	per	lower extremity of	oep vern 41	19m085	13		101	es 2 No	3 Prot	oably 4 □Unknown
ecc	law ras be	Completed						24a. Was			ppsy findings available impletion of cause of
		Con						perfo	rmed?	death?	2 No
Vital	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	5.1				of Death Check only o	ne		
of	di is	은	TE TES ZENO		ER/Outpatien				lence 6 Oth		у)
	ding Ph h. After th funeral	lon	27. Man r of Death 1 ≝Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280	Injury at Work? 1 ☐ Yes 2 ☐	28d. Describe h	low injury occur	red	
Division	deat deat ctor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	home farm str				Street and Numb	er or Rur	al Route Number,
÷	i the	Certification;	4 - Homicide d termined	building, etc. (Spec	ify)			City or Ton	m, State)	0, 0, 1,0,2	arroato reambes,
	To the Hospital within 24 hours a To the Funeral C completely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kr	owledge, death	occurred at	the time, date an	id place, and due to the	cause(s) and ma	inner as s	tated.
	he Ho n 24 i he Fu	edical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	ation and/or inv	estigation, in	my opinion, dea	th occurred at the time,	date and place,	and due to	the cause(s)
	To the total	Σ	29b. Signature and title of certifier	1 000		29c. i	icense number		29d. Date signe	d (Month.	Day, Year)
			1 Jaislus Blade	dy, IND		_AJ	41473	57-T1089	Febr	utel	3,2005
	1		30. Name and address of person who co	mpleted cause of death (Ite	23a) (Type,	Print)	mal Da	Mala -~	2 0 .11.	0	WV -1
	4	111.11.5	Jarshri Blakeley 1	32. Registrăr's Sigr	TH M	HTE S	HEET 19	Aviaugy 50	1 POTAL	rnary	1110 2128)
	Sta	ite rar		005	L	1. 10		•		•	

		1 - State Registrar AMEND ITEM #16a, 17, 18, 20a		artment of Health a piticata (1840at/)	09/05 JH R	eg. No. UU5	03451
Physi		1. Decedent's Name <i>(First, Middle, Last)</i> Easton E. Roach			2. Date of Deat Month January	Day Year	3. Time of Death 6:21 AM M
/Med Exam		4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice		4b. City, Town, or Location of Baltimo	of Death	4c. County of Dea	
Funera Directo		5. Social Security Number unk 6. Sex 1 M M 2 □ F 7. Age (In yrs. 53	last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birth (Month Day, Oet 21,	9. Bir 1951 Ja	thplace (State or Foreign cuntry) IMAICA
yland now		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y. Town or Lo	cation			10d. Inside City Limits
death with the Maryland ms 23a or 28a-t show froust be notified at	Director	MD Anne Arundel	G	len Burnie			1 ☐ Yes 2X No
with the	Dire	10e. Street and Number 7501 Whaler Court		10f. Zip Code	1	0g. Citizen of What Co	
death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.	.S. 13. V	21061 Was Decedent of Hispanic Orio f Yes, specify Cuban, Mexican		Jama 14. Race - Ame	erican Indian,
ING ZIZIS-UUSO be filed within 72 hours after death with the Marylan ttal Hygiene. id other than "natural", or items 23a or 28a-1 show event, the Medical Evantinet must be notified at	by	1 X Never Married 2 Married 1 Pes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuban, Mexican □ Yes 2X No Specify:	i, Puerto Rican, etc.)	Black, Whit	e, etc. black
in 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	t of working unk	16b. Kind of Business	Industry unk
a filed within al Hygiene. other than "	Somp	Elementary/Secondary (0-12) College (1-4or 5+)		ARMER			
be file tal Hy od other event	Be	17. Father's Name (First, Middle, Last)			er's Name (First, Middle, M	Maiden Sumame)	unk
larylan 2 should be and Mental is marked o	5	WILLIAM ROACH 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	ng Address (Street and Number	TA HYLTON	City or Town State	Zin Code)
12 a a a a		Felicia Wilson/daughter		Whaler Court		-	
MOFe, Pages 1 ar		XX Burial 2 Cremation 3 Removal from State	emetery, cren	sition (Name of natory or other place)		20c. Location - City or	Town, State
그 문문를	ej o	21. Six ature of Finer I Service Licensee adde, Dizzector	r Š	Name and Addr ss of Facility L	STALLLINGS		
Pnysiciar /Medica Examine	n i	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	n. Do not ente		morris	est,	Approximate Interval Between Onset and Death
. BOX bd / bU, death certificate be executed e attending physician and id for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			O(X) (X	ZA C4	47700
GOIGS, P.O. BOX D8/D0, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
ords, F.C requires that the een signed by th rould be detache	by P	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause given in Part I.		pacco use contribute to	
N G S CV	Completed				24a. Was ar autops perform	n 24b. Were au prior to death?	itopsy findings available completion of cause of
	Be C	25. Was case referred to medical examiner?		26. Place	of Death (Check only on		242140
Phys rithis raldi	ertification: To	Hospital:	ER/Outpatien 28b. Time of Injury		1	nce 6 Dother (Spenow injury occurred	city) HOSPICE
DIVISION al or Attending s after death. I Director: Afte	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ht building, etc. (Specify	ome, farm, stre	eet, factory, office	28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
e Hos pit 24 h un e Furèra letely fille	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medicel Exeminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, date and restigation, in my opinion, deat	d place, and due to the ca th occurred at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
To th within To th compl	₹ Z	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Monte	h, Day, Year)
24		mha althele	M	1 7326	000	1251	05
2		30. Name and address of person who completed cause of death (Item	1001	-fe ST.	Baltima	MP, MC	21287
S Regis	State strar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	B. A.	DENE !			

		-	State of M.		artment of H		lental Hygien	ZUU5 H3652
	Physicia /Medic	an al -	1. Decedent's Name (First, Middle, Last)		dh Cin Tura	Landing of David	2. Date of Death Month Da	Year Year 3. Time of Death
	Examin Funeral Director		213-05-3734 ¹ X ^{M 2□ F}	e (In yrs. last birthday) 88 Yrs.	Rangi	If Under 24 Hrs. Hours Min.	8. Date of Birth SEP. 14,191	9. Birthplace (State or Foreign Country) MD
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo	ocation IMORE			10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	death with the Marylan ms 23a or 28a-f show must be relified at	ral Director	10e. Street and Number 6117 BERKELEY AVENUE #B-1		10f. Zip Code	21209		itizen of What Country? USA
980	ours after ral', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	⊆ . c .	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired RIETOR	turing most of work	ing	Cind of Business/Industry
nd	2 should be filed with and Mental Hygiene is marked other that eumatic event, the formatic event, the formatic event, the formatic event.	To Be (17. Father's Name (First, Middle, Last) ISIDORE	RICH	MOND	18. Mother's Nam	e (First, Middle, Maide.	n Sumame) POTTS
	12 E E		19a. Informant's Name/Relationship (Type, Print) MILDRED RICHMOND / WIFE	6117	BERKELEY			or Town, State, Zip Code) 10RE, MD 21209
Baltimore,	Pages nent of ant: If it ary or o		20a. Method of Disposition 1	1	osition (Name of amatory or other place) I CEMETER	θ)	20c. L 1/2005	OWINGS MILLS, MD
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee Edward Cr Runs					& BROS., INC. SVILLE, MD 21208
	Medical / Medical / Medical / Medical / Medical / Medical / Manual - Itausit / Medical	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of): a consequence of):			direspiratory arrest,	Approximate Interval Between Onset and Death
O. Box 68	ne death certific the attending p hed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy			23d. Date of delivery Month Day Year
rds, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to death t	out not resulting in the t	underlying cause give	en in Part I.		use contribute to the cause of death?
		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital	S S	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatie	ent 3 DOA Othe		h (Check only one) me 5 Residence	6 ☐Other (Specify)
	Jing After funel	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28a. Date of Inj (Month, Date of Inj	y Year) Injury jury - At home, farm, st	M 1 🗆	<br Yes 2 □ No	28d. Describe how inju 28f. Location (Street a	nd Number or Rural Route Number.
Ö	spitei or nours afte nerei Din / filled in I		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, dea	th occurred at the time	ne, date and place,	City or Town, State	c) and manner as stated
	To the Hospitei within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner stands and manner stands.	of examination and/or in ated.	nvestigation, in my of			ate signed (Month, Day, Year)
	ŭ ⊶ € ⊶		Alice Hoy		1-1	+3974:		
	3		30. Name and address of person who completed cause of	death (Item 23a) (Type	Print)	6 201	leu cto	hart 1
	Sta Regist			rar's Signature	parti		kell stown	en yezan

DHMH 17 Rev 1/2001

		-	For St	ate of Maryl		artment of H tificate of L		Mental Hygie	ene 3. 2005	03454
	Physicia /Medic Examin	ai	Decedent's Name (First, Middle, Last) Mary As Facility Name (If pot institution, give stree)	S.		Schrei 4b. City, Town, or		2. Date of Death Month Februar	Day Yea Yea Ac. County of De	05 1:45 A M
	Funeral Director		NOR+H + Runce + 5. Social Security Number 6. Sex 220-12-4813		yrs. last birthday) 78	If Under 1 Year Months Days	Hours Min.	(Month, Day, Y		HRUNDE inthplace (State or Foreign Country) aryland
	ס	7.	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	100.	City, Town or Lo	_		1100. 12	1520 110	10d. Inside City Limits 1 ☐ Yes 2X No
	after death with the Maryland or Items 23a or 28a-f show cult et must be collitied at	ai Director	10e. Street and Number 7032 Conley Street	et	Lasewood	10f. Zip Code	24	100	g. Citizen of What (Country?
) 		by Funeral I	11. Marital Status 12. V	Vas Decedent Ever i imed Forces? ☐ Yes 2 ☐ No Yes, Give ear or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ② No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
1215-0	filed within 72 hours after Hygiene. ither than "natural", or Ite int, Ita Medical Examire	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	orking 16	6b. Kind of Busines	·
Mahd	ould be filed Mental Hygi Markad other	To Be C	17. Father's Name (First, Middle, Last) Alexander		Beczkow	ski	Kathei		aiden Sumame) Sko	obocinski
altimore, Maryland 212	s 1 and 2 sh if Health and Itam 27 is in other traum		20a. Method of Disposition	(Daughter	r) 8232 Db. Place of Dispo	Rupert R	oad Nort	th Millers Date Cuary 9,	•	d. 21108
C'HE Baltimo	permit. Pages 1 and 2 should be Illed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other fraumatic event, ILE Magnee.		1 ⊠ Burial 2 □ Cremation 3 □ Remo '4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service □ ense	val from State	St' Stan	islaus 2 Name and Addres W. Dabrow	ss of Facility	2005 B jnacki Fun	eral Home	, Maryland
	Physician /Medical Examiner		23a. Part1. Inter the disease, or complicatic shock or hear failure. List only one complications are conditions. Immediate Cause (Final disease or condition resulting in death)	Sep Si				Baltimore		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a cor	nsequent e of):	1				
P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months?	f yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of o	delivery Day Year
ords, P	equires that sen signed b ould be deta	by	Part II. Other significant conditions contributions	uting to death but no	t resulting in the u	inderlying cause giv	en in Part I.			to the cause of death? Probably 4 Munknown
al Rec	n: The law r ficate has be rr, page 2 sh	e Completed	Coto way and	ly disa	asc				ed? prior t death No 1 □ Y	autopsy findings available o completion of cause of ? es 2 \(\subseteq\) No
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death certifics within 24 hours after death. To tha Funaral Diractor: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	To B	examiner?	ital: 1 Inpatient 8a. Date of Injury (Month, Day Yea	2 ER/Outpaties 28b. Time of Injury	of 28c. Injur Wor	er: 4 🗆 Nursing	eath (Check only one Home 5 Residen 28d. Describe how	nce 6 Other (S	pecify)
Divisi	ital or Attar urs after dea iral Diractor lled in by the	Certification;	3 Suicide 6 Could not be determined 2	8e. Place of Injury - building, etc. (S)	pecify)			City or Town,	State)	Rural Route Number,
	To the Host within 24 hor To tha Funa completely fi	Medical	(Check only 2 Medical Examiner:				pinion, death occ			lue to the cause(s)
4	01		30. Name and address of person who compl	eted caus, of death	(Item 23a) (Type	Print) Da	35991 Hasa	ital bri	spring	6 HV 2MS
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Pagistrar's S	Signature	brack .			1	4b 21061

			1 - For State Registrar	State of Man		artment of F		Reg	ene .No.2005	03455
	Physici /Medi	cal	1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, giv	verve !	Schwa	rtz,	Location of Death	2. Date of Death Month	Day Year 30 Z005 4c. County of Death	3. Time of Death
	Examir Funeral Director	ier	402 PACKAR 5. Social Security Number 6. S	D AVER	n yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	Bur If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Jan. 10,	A A 9. Birtho	olace (State or Foreign htty) Land
	be filed within 72 hours efter death with the Maryland ital Hygiene. Id other than *natural', or Items 23e or 28a-f ehow of other than *natural', or Items 23e or 28a-f ehow event, the Medical Examinar must be notified at	Funeral Director	10a. State 10b. County Maryland Anne Art 10e. Street and Number 402 Packard Drive	ındel G	Oc. City, Town or Lo			Un	Citizen of What Cour ited State America	Od. Inside City Limits 1 □ Yes ¾∏No ntry?
9800	ours efter dea iral', or Items Examiner mu		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Overced	12. Was Decedent Eve Armed Forces? 1 □ Yes 21XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※XX No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No-	14. Race - Americ Black, White, Specify: Whit	etc.
21215-0036	filed withln 72 h Hygiene. ther than "natu int, Ine Medica	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	during most of work	ing	b. Kind of Business/In Building	dustry
Maryland 2	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last William Laverne S	Schwartz, Sr				e (First Middle Mai laine Wat	iden Surname)	
Baltimore, Mar	es 1 and 2 s of Health ar if item 27 le or other trau		19a. Informant's Name/Relationship (William Laverne S 20a. Method of Disposition 1\text{\text{\text{M}}} Burial 2 □ Cramation 3 [4 □ Donation 5 ② Other) (Species)	Schwartz, II	I 9615 20b. Place of Dispo cemetery, cres	Blackamor	re Circle Feb.	Houston 200 4,	ity or Town, State, Zip Texas 77 Location - City or To Itimore M	065 wn, State
■ Balt	permit. Pag Department Importent: I any injury o		2) Signature of Funeral Style Liberton Company	nsee * plications that caused the	22	2. Name and Addres	ss of Facility Lou 362 Ba1	don Park O Wilkens timore, M	Funeral Ho Avenue aryland 21	me 229 Approximate Interval Between
68760,	Physician /Medical /M	icai Examiner	Inimediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lary, learning to impediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	evotic	/teart	- D15	enso	Onset and Death
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to th	. 4
Vital Records,		e Completed	25. Was case referred to medical				00 Pl 1 P 11	24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of 2 No
of	ling Phys I. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	9r: 4 ☐ Nursing Ho	n <i>Check onl one</i> me 5 A Residence 28d. Describe how i	e 6 Other (Specify)
Division	- 9	Certification;	3 Suicide 6 Could not be determined	building, etc. (S	Specify)			City or Town, S		
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying PI (Check only one) 2 Medical Example 29b. Signature and title of certifier	nysician: To the best of miner: On the basis of examiner stated	amination and/or inv	vestigation, in my op	pinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
,	5	1	30. Name and address of person who	completer cause of death	(Item 23a) (Type,	Print)	0605.	ef 1	1/31/5 2+ 21	035
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrars		Spell	MIMEN	CHT C	1 2.	

		1 - For State Registrar	State of Marylan	-	tificate of			leg. No. 20	05	0345
Physic	an	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day	Year	3. Time of Death
/Medi	cal	MARY FRANCES	STRICKLAND		# 05 T			ry 2, 20	05	3:28 a M
Exami	er	4a. Fecility Name (If not institution, give Laurel Regional Ho			Laurel	or Location of Dea	th	4c. County		orge's
Funeral		Social Security Number	7. Age (In yrs. I	ast birthday)	If Under 1 Year			1	9. Birthp	lace (State or Foreign
Director			^{1 M 2} ₹₹ 76	Yrs.	Months Days	Hours Min	Nov. 1		Coun	yland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Maryi -f eho	tor	MD Prince G		urel						1∏Yes 2∏No
death with the Maryland ms 23a or 28e-f ehow rmat be notified at	Director	10e. Street and Number	20190 5 20	4101	10f. Zip Code		1	log. Citizen of W	hat Coun	
th wit	aiD	7901 Laurel Lakes	Court #318		20707			U.S.A.		
tems ferms	Funeral		12. Was Decedent Ever in U. Armed Forces?		Was Decedent of f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		- Americ	an Indian, etc.
rs afte	by F	1 Never Married 2 Married 3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 XXVo If Yes, Give Year or Dates:		¹⊡Yes 2 X DKNo	Specify:			Whi	
2 hou atura	ted	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occu	pation		16b. Kind of Bus	siness/Inc	dustry
thin 7 e an "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	orking			,
2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene is marked other than "natural", or items 23a or 28e-f ehow aumatic event, the Medical Examinat must be notified at	Son	Grade 12		Rece	ptionist	1		Food S		ce Co.
d be fi	Be	17. Father's Name (First, Middle, Last) James Otto Weisenb	ora				me (First, Middle,)	
d 2 should be file th and Mental Hy 7 is marked oth traumatic event	2	19a. Informant's Name/Relationship (Ty		Rose Ella Combs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod						Code
12 mg		Diane M. Hurst /	daughter				rt Laure			
of He of He of He of He of He		20a. Method of Disposition				20c. Location - 0				
Page mant ent: if ury o	20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20c 20								, Mai	ryland
permit. Pages 1 e Department of Hez Importent: it Item any injury or othe		21. Signature of Funeral Service Licens	90	D D	Shalason	Funeral	Home, P.A			
20540		47 ST	/ M00'				e Laurel		and	20707
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final	ne cause on each line.			ing, such as carola	ic or respiratory arr	est,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	. Myocardia. Due to (or as a consequ		rction				-	
Examiner			Chronic Ob		tive Lun	g Disease	2			
₽ ≅	Iner	Sequentially 1st conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
be executed iclan and burial-transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	Congestive		t Failur	е			_	
be exictant	ш		Due to (or as a consequ	Jence or):					1	
ificate g phys	dic		1							
death certificate be ex e attending physiclan d for use as tha buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date	of delive	ry
death	sicia	in the past 12 months? 1 🗆 Yes 2 🕮 No	1 Live birth 2 Fetal 4 Pregnant at time of de]Ectopic pregnand] Other <i>(specify)</i> _	;у 		Mon	th	Day Year
nat the ded by the a	Phy	9 Unknown								
requires that	by	Part II. Other significant conditions con Degenerative Jo.		alting in the u	nderlying cause gr	ven in Part I.	23e. Did to	_		e cause of death?
N 0 70	Completed	Degenerative 00.	inc Disease							ably 4 Unknown
sician: The law cartificate has b irector, page 2 st	mpi						24a. Was a autops perfor	an 24b. W sy pi med? de	/ere autor rior to con eath?	osy findings available appletion of cause of
	e Co	25. Was case referred to medical				OC Place of Do		2\(\infty\) No 1	Yes	2 X X No
Physician: this cartific	To B	examiner?	lospital: 1 ☐ Inpatient 2🔀	26. Place of Death Check on one tpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					•)	
ding Phy. h. After this funeral d		27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	b. Time of 28c. Injury at 28d. Describe how injury of					,
tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No							
or Attending after death. Director: Afte	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str /)	eet, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	r or Rura.	Route Number,
spite ours nerel		29a. Certifier 1XXertifying Phy	sician: To the best of my kno	wiedge, deati	occurred at the t	ime, date and place	e, and due to the c	ause(s) and mar	ner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exami	ner: On the basis of examinat and manner stated.	tion and/or in	estigation, in my	opinion, death occ	urred at the time, d	late and place, a	nd due to	the cause(s)
To th To th	Ň	29b. Signature and title of certifier	10 Altendi	1,0		se number		29d. Date signed	-	Day, Year)
	1	Venuillon.	11) HOHWOT	W).	D 42	2580		02/03/20	005	

Registrar DHMH 17 Rev 1/2001

State

9 P

#13 Bladensburg, MD

20710

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 7 2005

P.S. Aujla, M.D.

31. Date filed (Month, Day, Year)

5632 Annapolis Road

32. Registrar's Signature

			For	State of	Marylan		artment of		ı mental Hy	/giene		
			State Registrar			Ce	rtificate of	Death		Reg. No.	905	03157
Ph	ysicia	ın	Decedent's Name (First, Middle, I	Last)					2. Date of De Month	eath Day	Year	3/ Tiple of Death /
	Medic camine		Yesotha 4a. Facility Name (If not institution, g	give street and numi		bandam		or Location of De	Februa		2005 unty of Death	11:20pm [™]
			10434 Kingsbridge				Ellic	ott City	7		Howar	
	eral ector			. Sex 7 1 ☐ M 21 ☐ F	7. Age (In yrs.	last birthday) Yrs.	Months Days		in. (Month, D	rth ay, Year)		place (State or Foreign htry)
	Ctor		220-37-1633 Usual Residence of Decedent		80				Feb. 1	0, 192	24 I	ndia
inylan	I I	_	10a. State 10b. County		10c. Cit	ty, Town or L	ocation				1	0d. Inside City Limits
9 1-98	Allie	ecto	Maryland Howard	d		E1	licott C	ity				1 ☐ Yes 2 🏋 No
with t	DE D	Funeral Director	10e. Street and Number	D 1			10f. Zip Code	01010			of What Cour	ntry?
Jeath	ED .	era	10434 Kingsbrid	12. Was Deced	dent Ever in U	.S. 13.	Was Decedent of	21042 Hispanic Origin?	(Specify Yes or N		dia Race - Americ	can Indian.
after o	THE STATE OF	F	1 ☐ Never Married 2 ☐ Married	Armed Ford 1 Yes 2 If Yes, Give Year or Dat	ces? ZX∏No	i			(Specify Yes or Nerto Rican, etc.)		Black, White,	
Sours Jel.	Era	d by	3√ Widowed 4 Divorced		tes:		1□Yes X∏No	Specify:				n-Indian
If year I U Z I Z I J-UUJO should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "naturel", or items 23e or 28e-f show	other treumetic event, the Madical Exacutational Legicalities at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	edent's Usual Occu a kind of work done DO NOT use retire	a during most of v	vorking	16b. Kind	of Business/Inc	dustry
within the	V.a.M	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		Homemak				Own Hor	m o
e filed	vent,	BeC	17. Father's Name (First, Middle, La	st)			пошешак	1	lame (First, Middle	, Maiden Su		ile
Menta	otic e	2	P.T. Veeraragha	avan Mud	aliar			Rad	ha Ba	ai		
ts bu	3 1		19a. Informant's Name/Relationship						Rural Route Numb			
Tand 1 and 1 ealth	thert	1	Umaderi Anandakr	ishnan/da			4 Kingsbi	ridge Ro	ad Ellio			
permit. Pages 1 and 2 Deportment of Health a	0 0 0		1 ☐ Burial 2 🖔 Cremation 3			cemetery, cre	matory or other pla	ace)	Date	20c. Locat	ion - City or To	own, State
it. Pa	ujuu	Ī	 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice 		West	t Arune	del Crema	atory 2/	6/2005	Odeni	ton, Ma	ryland
Dep-r	any once		Musita QUI	D-	3404	7057	Donaldson	n Funera	1 Home &	Crema	tory, F	P.A.
	n _a n		23a. Parti Enter the disease, or co shock, or heart failure. List on	omplications that car	used the deat	th. Do not en	411 Annai	polis Ko	ad Odeni	con, Ma	aryland	Approximate
Physi		Į		ily one cause on ear			tor the mode or dy	ing, such as card	lac or respiratory a	arrest,		Interval Determinate
	cian l		Immediate Cause (Final									Interval Between Onset and Death
/Med	lical		disease or condition resulting in death)	a Due to (o		STIVE			AILUR			Interval Between
	lical iner		disease or condition resulting in death)	Due to (o	ONGES or as a conseq ERO SC	STIVE quence of): LE 20	HEA	RT F		E		Interval Between Onset and Death
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DHMH 17 Rev 1/2001

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		For State Registrar		State o	f Mary		epartr <i>Certifi</i>				nd M	lental Hy	gien Reg. N	000	034	58
		1. Decedent's Name										2. Date of Do		ay Year	3. Time	of Death
Physicia /Medic		Millard	E	11sworth		Shoem	aker,	Sr.				Januar	y 3	0 2005	8:00	a ^M
Examin		4a. Facility Name (/	f not institution,	give street and nur	nber)		4b	City, Tow	vn, or L	Location o	f Death			c. County of De		
				Veterans				harlo						t. Mary		
Funeral		5. Social Security N 578-16-0		6. Sex 1)XΩM 2□F	7. Age (In	yrs. last birt			ays	Hours	Min.	8. Date of Bi (Month, D	a <i>y, Yeai</i>	9. 8	irthplace (State Country)	or Foreign
Director		Usual Residence of			00	,						NOV.	.0,	1918 Wa	sningto	n, DC
yland		10a, State	10b. County		10	c. City, Town	or Location	n							10d. Inside	City Limits
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permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra			Cremation	3 Removal from	1	cemeter	y, cremato	ry or other	r place							
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		30. Name and add	fress of person	who completed cau	se of deat	h (Item 23a)	(Type, Prir	it)								
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Sta	ate	31. Date filed (Mo	nth, Day, Yelar)	32.1	Registrar's	Signature										

Registrar

DHMH 17 Rev 1/2001

FEB 0 7 2005 Been & Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.- U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** teb . OUPM 2005 Estella Mae /Medical Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hos - MOGE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 79 Yrs. Director 214-24-7332 06/22/1925 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "naturaf, or items 23a or 28e-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Medical Everth at must be notified at 14 Yes 2 No Director <u>Maryland</u> Baltimore Partine Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Completed by Funeral 3318 Brighton Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moses Watson Carry Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizzie H. Caldwell / Sister 3318 Brighton St., Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages i Department of F Important: If ite any injury or otl once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Landsdowne, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 02/09/2005 Mt. Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. Sonature of Funeral Solvice Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetjand Death Immediate Cause (Final **Physician** day orad. Caso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter uncernying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a use as the burial-transit 0 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Thknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 [] No 2 No 1 ☐ Yes 1 TYes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1☐ Yes 2☑ No 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0053003 Sician a

State Registrar DHMH 17 Rev 1/2001 Layode

31. Date filed (Month, Day, Year)

FEB 0 7 2005

Caton

P.O. BOX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawsence

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** xanuar: SHIRLEY L. SWANN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENERAL aRylana N/A If Under Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-22-1937 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□M 2X F 212-36-4722 Director 67 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Evaniner must be notified at MD. N/A BALTIMORE 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 722 DOLPHIN ST. USA Items 23g 21217 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 1 ☐ Yes 2 ◯XNo If Yes, Give Year or Dates: Specify: Specify: BLACK 3√ Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) -12--0-HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) Be BERTIE CARROLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES HARRIS (BROTHER) 8841 HARKATE WAY BALTIMORE, MARYLAND 21133 of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cramation 3 □ Removal from State ö Department of Importent: If eny injury or one 2-3-05 BAZTO, MARYLAND AUBURD COMETOCY ` 4 ☐ Donation & □ Other (Specify) HIBNERName and Address of Facility REDD FUNERAL SERVICE 21. Signature of Juneral Service License JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dheart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Cther (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, this

				1 ☐ Yes	2 No 1 Yes 2	2 🗆 I
25. Was case referred to medical	125		26. Place	e of Death (Check only	one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatient	3□ DOA Other: 4□ N	ursing Home 5 Res	sidence 6 Other (Specify)	
27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injury at Work?	28d. Describe	how injury occurred	

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	l.
(Check only	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	caus

se(s) one) and manner stated 29b. Signature and title of certifier

ddress of per in who completed cause of death (Item 23a) (Type, Print)

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State

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Certification;

Medical

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within 24 hours a To the Funerel (pellij

			For State 1 - State Registrar	of Maryland / Depa	artment of He		ntal Hygien	611115	03451
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	/Medic	al	CATHERINE	5m			-eB. 04	2005	12 20 P.M
	Examin	er	4a. Facility Name (If not institution, give street and BAILIMORE Bridge	-VICW/BAYVIEW	4b. City, Town, or I	Location of Death 1 + 1 reose	40	c. County of Death	
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation			11	0d. Inside City Limits
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	or 28	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Coun	itry?
	s 23e	rai	3515 E. FAIRMOUNT		212:			U.S.A.	
	fter de	Funerai	1 Never Married 2 Married 1 □ Y	es 2 XNo	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Specr n, Mexican, Puerto Ri	ty Yes or No- can, etc.)	14. Race - America Black, White, e	
8	ral', o	by	3 ☐ Widowed 4 ☐ if Yes Year	, Give or Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify: WH	ITE
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Maryland 21215-0036	should be ind Mental s marked o umatic eve	To Be	CHARLES KOLB		ELIZA	BETH BA	AST		
Mar	12 shoth and 7 is m		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a				
	Health tem 27 other to		JACQUELINE REILLY/	20b. Place of Dispe	osition (Name of	Dat		ocation - City or To	
Ē	Pages nent of I int: If its iry or o	3	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal file 4 ☐ Donation 5 ☐ Other (Specify)	om State	matory or other place CREMATO	· 1	5 BAI	TIMORE.	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examilise in Intilia and Once.		21. Signature of Funeral Service Licensee		2. Name and Address				
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	200		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	nat caused the death. Do not en	ter the mode of dying	, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	o to (or as a consequence of):					14 days
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ord	w requir been si should I	eted	DEMENTIA	1			1 Tes 2	No 3 Proba	ably 4 Unknown
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ta	an: Tr lifficate or, pag	a	25. Was case referred to medical			26. Place of Death (1□ Yes 2□N		2 No
Ţ	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital:	□ Inpatient 2 □ ER/Outpatie	Otho			6 ☐Other (Specify	()
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Division	Attending ir death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be 28e F	lace of Injury - At home, farm, st		'es 2 □ No	f. Location /Street a	nd Number or Rural	I Route Number
<u>S</u>	el or A s after if Direct	Certification:	4 Homicide determined	uilding, etc. <i>(Specify)</i>	,		City or Town, Sta	е)	
	To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only 2 Medical Examiner: On the	the best of my knowledge, dear ne basis of examination and/or in	th occurred at the time	e, date and place, an	d due to the cause(s) and manner as st	ated.
	To the within 2. To the complete	Med	one) and	nanner stated.					
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/,	\cap		30. Name and address of person who completed	cause of death (Item 23a) (Type	, Print)			- ;	
1	. /		Erwin TAN 2	OZYE. Ma	Numert	54.	2-700	5A/to.	10 21205
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 7 2005	cause of death (Item 23a) (Type 0 7 4 E	nerti				
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	Funeral Director		220-32-7764		tal e (in yrs. last 68	birthday) Yrs.	If Under 1 Year Months Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day, 07-04-1	Year)	Coul	place (State or Foreign
Maryland 21215-0036	4.2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other then "natural", or flems 23a or 28a-f show traumatic event, the Medical Exactinating the notified at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Movinorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, La Charles A. 19a. Informant's Name/Relationship	Ave. 12. Was Decedent Armed Forces? 1	11	13. V	Nas Decedent of H f Yes, specify Cuba I □ Yes 2 □ No dent's Usual Occup- kind of work done of the coordinate of the c	Specify: ation during most f) de 18. Mothe	or's Name able	g (First, Middle, I Route Number	USA 1. 16b. Kin 16b. Kin 16b. Kin 16b. Kin 16c. Kin 16c. Kin 16c. Kin 16c. Kin 16c. Kin	en of What Cour A. 4. Race - Americ Black, White, Specify: Blac d of Business/In ice of (Sumame) Town, State, Zip	can Indian, etc. ack dustry Queen Annes
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic es once.		Rosalind Y. Mars 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service Lie	Removal from State	20b. Place ceme	of Dispo etery, cren	4 Concord sition (Name of natory or other place Church Co Name and Address Bennie Si 426 Dove	em. 0	2-05- Funer	·2005	Gras	sation - City or To $sonvill\epsilon$	own, State
8760,	Medical Medical Medical Medical Examiner	dical Examiner	23a. Part Sinter the disease, or co shock or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that intitated events resulting in death) Last	a	a consequent	ce of):	er the mode of dyin	g, such as	cardiac or	respiratory arm	est,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23	3d. Date of delive	ery Day Year
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			For State Registrar	State of Marylar		artment of Hotelin		, ,	giene 100 100 100 100 100 100 100 100 100 100	03463
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			RUXTON HEALTH &	REHABILIT	ATION		SVILLE		BALTIMO	RE
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		olace (State or Foreign
	Director		Usual Residence of Decedent	M 2□F 59	Yrs.					RYLAND
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	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28a-f show ta Macinal Exandibut must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian,
9	or its	正	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2/XNo		1 □ Yes 🏋 🛱 No	Specify:	7 110dri, 610.)		
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
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9	ificate g phy as the	Physician/Medicai								
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			Jaseien (Xalllan		12	2828		2/1/15-	
	2		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type,	Print)		0	1	2
		•	TASNEEM LARY	Htmy, 7220		RK HE	1CHTS.	1+15	DAUTO 1	11) 21208
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 28 **Physician** Lionel W. Thompson January 2005 3:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 Ann a DOLLS

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 0ct | 22 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1QM 2□F 217-26-3196 74 1930 Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 28e-f show other traumatic event, the Medical Exerginary unit be notified at Maryland Anne Arundel Churchton MYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 953 Franklin Manor Rd. 20733 USA Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) West River al Hygiene. Efementary/Secondary (0-12) Coflege (1-4or 5+) Maintenance 8th Church Camp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o Porter Thompson Susie Turner ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 I Sarah M. Thompson(Wife) 953 Franklin Manor Rd. Churchton, Md. 20733 20b. Place of Disposition (Name of Lackremonate) a 1 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 2-3-05 Gardens Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Zazry H. Rese MO0483 821 West St. Annapolis,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemie Heart Discare he /Medical Due to (or as a consequence of) Examiner DOYCOM mpertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending physical for use as the b 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 60,0 Discase 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed2 certificate 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 🖼 No 3M DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural м 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38563 arban anne D January 31, 2005 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 3 (cibay m) 1. 134 onensvilla Rd Wayne D. 31. Date filed (Month, Day, Year) FEB 0 2005 Donly State 1 1 1 1 5 M Registrar

ician dical	1 - For Amend Item 1 - Registrar 1. Decedent's Name (First, Middle, Laverne W. Vi		Laver		ughan	Jean I		2. Date of De Month	eath Day		Year 2005	3. Time of Death
niner		give street and nu	HosPi	TAL	4b. City, Town, or	Bu	RN	15	4c.		of Death	RUNDEL
al or	219-52-6862	S.Sex 1 □ M 2 TXF	7. Age (<i>In yr</i> s. 6		Months Days	If Under 24 Hours		8. Date of Bi (Month, D Sept	rth av. Year! 2 19	36	9. Birtho Coun N • C	ace (State or Fore try) arolina
5	Usual Residence of Decedent 10a. State 10b. County Maryland N/A			y,Town orLo							10	Od. Inside City Limi
Directo	10e. Street and Number 751 W. Sarato			Dal CIII	10f. Zip Code	1					What Coun	1 □ Yes 2 □Xt try?
/ Funeral Director		12. Was Dec	2 XNo		/as Decedent of His Yes, specify Cuban		n? (Spe Puerto l	cify Yes or No Rican, etc.)	0- 1	Blac	e - America ck, White, e	etc.
Completed by		Year or D Education grade completed)	ates:	16a. Deced	ent's Usual Occupation of work done du O NOT use retired)	ion	of workir	ng		Specify	usiness/Ind	a.c.k lustry
e Comp	Elementary/Secondary (0-12) 3 r d 17. Father's Name (First, Middle, La	College (1-4or 5+)		<u>ekeepinc</u>	,	s Name	(First, Middle		lot:		
To Be	Collin Green			19b. Mailin	Address (Street ar	Myra	Si	.1va				Code)
	Sonia Holland(8010	Carlean		Pas		, Mo	1. :		2
zonce. To Be Comp	1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Control of Funeral Service Li	cify)		yland	Veterar	1 2	-4-	05	Crow	ns	vi11e	e, Md.
Suca	Lavy &.	Leese M		8	<u>Zl West</u>	St.	Ann	apoli	S, M	íd.	2140)1
n al	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lice. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ke Oue to Due to	or as a conseq	Tail Inm uence of):	nodet	(Ci	enc	°y 5	yndi	(D)	ne	Days Meath:
Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 No 9 ☐ Unknown	1☐Live b 4☐Pregn	come of pregna irth 2 Feta ant at time of down	death 3	Ectopic pregnancy Other (specify)				23	3d. Dat Mor	e of deliver	y Day Year
b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										a cause of death?	
Completed							-	24a. Was auto perfo 1 Yes		þ	rior to com leath?	sy findings availab pletion of cause of 2 No
To B	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (
Certification:	3 Suicide 6 Could no determin	ad 28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory, office		2	8f. Location (City or Tox	Street and wn, State)	Numbe	er or Rural	Route Number,
edical	29a. Certifier (Check only one) Certifying Condition (Check only one)	Physicien: To the aminer: On the ba and mann	asis of examina	wledge, death tion and/or inve	occurred at the time estigation, in my opin	, date and p	occurre	nd due to the d at the time,	cause(s) a date and p	and mar place, a	nner as sta nd due to t	ted. the cause(s)
×	29b. Signature and title of certifier	Auic			29c. License r) 32°	7 -			-	(Month, D	ay, Year) 0,2005 1AMD
	30. Name and address of person w	o completed caus	e of death (Item	23a) (Type, P	rint)	1 A =		111		1	1	1

			rieasi	State of M							_	ibie.		
			1 - For State Registrar	Claic of M	arytaric		tificate of		, , , , , , , , , , , , , , , , , , , ,		leg. No. 2 (005	034	66
			Decedent's Neme (First, Middle, I	.ast)					2.	Date of Dea	th Day	V	3. Time of D	eath
	Physici		1-10	ward		R.	Walk	<er< td=""><td></td><td>Month OZ</td><td></td><td>Year .005</td><td>615</td><td>AM</td></er<>		Month OZ		Year .005	615	AM
}	/Medic Examir		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of	Death		4c. Count	y of Death		
			JOSED	h Ric	hey		Ba	140				NI	9	
	Funeral Director		214-20-7722	Sex 7. Ag 1☐xM 2☐F	ge (In yr s . Ia 76	as <i>t birthday)</i> Yrs.	Months Days		4 Hrs. 8. Min.	Date of Birth	1 ⁴ 92/8	9. Birthp Coun	lace (State or try)MD	Foreign
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City	Limits
	Aarylan f show ed at	ō	MD N/A			LTIMOI							1 X Yes 2	2 🗌 No
	28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Coun	try?	
	3a or	ō	827 ARLINGTON A	TENUE			212	17			US	Δ		
	death ms 2	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. \	Was Decedent of I		in? (Specif	y Yes or No-		ce - Americ		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Mardical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 Tyes 2 If Yes, Give Year or Dates:	No		Yes 2 No		ruento mo	an, etc.)		ack, White,		
21215-0036	n *natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	during most of	of working		16b. Kind of E	Business/Ind	dustry	
212	d with giene grene	mo	10	College (1-40)	J.,	PA	INTER				MARY	LAND I	DRYDOCK	
	e file al Hy l othe vent.	BeC	17. Father's Name (First, Middle, La	st)				18. Mother	's Name (F	irst, Middle,	Maiden Suma	me)		
<u>/la</u>	Menti Menti arked	5 10	ALBERT WALKER					MA	ARGIE	TAYLO	R			
Maryland	2 should be filed within ? n and Mental Hygiene. 'is marked other than "r raumatic event, Its Mad		19a. Informant's Name/Relationship				g Address (Street						Code)	
	1 and 2 Health em 27	1	ANNIE MONROE/SI	STER	20h Pi		00 RIGGS sition (Name of	AVENUI	E, BA		MD ZIZ 20c. Location		wn State	
Baltimore,	9 5 5		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spe		CE	emetery, crer	LLE VET	2,	/10/0		ROWNSV			
Balt	permit. Pag Department Importent: any njury o		21. Signature of Funeral Service Lie	ensee (. Motte	5		Name and Address						S F.H.,	INC
	Physician /Medical		23a. Part Enter the disease, or construction of the street failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	CINO	maa	er the mode of dy	ng, such as co	ardiac or re	te w	rest,	etastas	Approximate Interval Between Onset and De	een eath Th
760,4	w requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Little to Jertyng Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as										
89	certificate Iding phys													
P.O. Box	the death cer the attendin ched for use	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[Ectopic pregnand Other (specify) _	у	-		!	ate of delive	*	ear
	requires that the een signed by the hould be detache	d by Pł	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying cause g	ven in Part I.		23e. Did to	obacco use con es 2 No		ne cause of de ably 4 □Ur	
Division of Vital Records,	e lar has	mplete							_		rmed?	death?	psy findings a npletion of car	vailable use of
a			25. Was case referred to medical		<u>-</u>			26 Class	of Dooth //	1 ☐ Yes Check only o	2X No	1 🗆 Yes	2 U No	
₹	Physician: this certific ral director,	To Be	examiner?	Hospital:	uent 2□	ER/Outpatier	nt 3 DOA O	har		5 Resid		ther (Snecif	y) HOSPI	104
on of	Itel Ine	tion: T	27. Manner of Death 1. Natural 5 Pending	28a. Date of Inj (Month, D		28b. Time o Injury	f 28c. Inju		280		now injury occu		,,,,,,	
Divisi	or Attending after death. Director: Alter in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At ho atc. <i>(Specif</i>)	ome, farm, st	reet, factory, office		281	Location (S City or Tow	Street and Num yn, State)	ber or Rura	l Route Numb	e <i>r</i> ,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier Check only one) Certifying 2 Medical E	Physician: To the bes kaminer: On the basis and manner s	of examinal	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and opinion, death	d place, and h occurred	d due to the o at the time, o	cause(s) and n date and place	nanner as si , and due to	tated. the cause(s)	
_	omple	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date sign	ed (Month,	Day, Year)	
	- 21-0		red C	Al	ele	\cdot	1	143			2/	6/0	05	
	· **		30. Name and address of person w		1 1	23a) (Type,		.1	Sec 5	, K	? ichea	y 14	725016	e.
	C.	ate	31. Date filed (Month, Day, Year)		trar's Signa	The second second	1 . 1/	00	10/1	//	11 -42	/ //	0 1/5 1	
	Regis		FEB 0			Le	1 .							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Registrar	Maryland / Dep	artment of F			ene 2005	031.6	
	hysicia		Decedent's Name (First, Middle, Last) Vera Hollowa	y Wentworth	1		2. Date of Death Month	Day Year	3. Time of Death	
FL	/Medic Examine Ineral rector		4a. Facility Name (If not institution, give street and num SAINT ACMS HEALT			r Location of Death ORE If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day,) eptember		place (State or Foreign	
	3		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	, p	ерсешьет		ginia 10d. Inside City Limits	
ө Магу!	e Marylan ta-f show	ctor	Maryland		W∑ Yes 2 □ No					
with th	Ba or 2	i Director	10e. Street and Number 517 Wildwood Parkway		10f. Zip Code 2122	0 1		ntry?		
Ind 21215-0036 be filed within 72 hours after death with the Maryland	0.9	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes. Give	No		ispanic Origin? (Specian, Mexican, Puerto Ri	United States lecify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black			
21215-0036 d within 72 hours aff	r then "natural", the Medical Exc	Completed b	3 X Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Specify: Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry							
nd 212 e filed with	=======================================		7th grade 17. Father's Name (First, Middle, Last)		Baker	18. Mother's Name (Food Servi	ces	
Maryland d 2 should be file th and Mental Hy	0 0	To Be	Soloman Holloway			Vivina	Green			
Mar nd 2 sho	other traumatic		19a. Informant's Name/Relationship (Type, Print)Eleanor Bullock (Daughte					City or Town, State, Zip		
Baltimore, Moemit. Pages 1 and 2		1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Si	20b. Place of Dispo	esition (Name of matory or other place	Dat		c. Location - City or To		
Itimor nit. Pages artment of	injury c		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	King Mem	orial Par			altimore, l	Mary land	
Balt permit.	Department Important: If any injury or once.		W. Wesley Co-	5 17	W. Wesley 22 North	Chavis II Capitol St	II Funeraret, N.	al Services	s, Inc. ton.D.C.	
	ician dical		23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause on ear disease or condition resulting in death)	used the death. Do not ent th line.	er the mode of dying	g, such as cardiac or r	espiratory arrest		Approximate Interval Between Onset and Death	
Exam	niner ial-transit	Exa	Seque, thatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	as a consequence of): T VENTRI as a consequence of): T as a consequence of):	CULAR DISA	HYDER-	TROPH	V +	work/ yoaks	
10 =	S L	edical	a. Hype	ASTENSIVE !	CERTON	HHOPHIH	У		en years	
- 0	tached for use as	Physician/M		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year	
Vital Records, P.O sicien: The law requires that the	90	2	Part II. Other significant conditions contributing to dea	ontributing to death but not resulting in the underlying cause given in Part I. DEMENTIA		n in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
I Rec	page 2 st	Completed					24a. Was an autopsy performed 1 ☐ Yes 2 ⊠	prior to com death?	osy findings available opletion of cause of	
VERA Of Vital F g Physician: Th	rector, I	e Q	25. Was case referred to medical examiner?	atient 2 ER/Outpatient	Othe	26. Place of Death (C		10 105	2 100	
on of ling Physics	funeral	ation: 10	1 Yes 2 No 10 No. 1 No.	4 Nursing Home	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
Division If or Attending after death.	d in by th	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, farm, stre , etc. (Specify)	eet, factory, office	28f	. Location (Street and Number or Rural Route Number, City or Town, State)			
Division To the Hospital or Attence within 24 hours after death	completely filled in		29a. Certifier (Check only one) (Check only on							
To the within	comple	Me.	29b. Signature and title of certifier	stateu.	29c. License	number	29d.	Date signed (Month, D	Pay, Year)	
	4		30. Name and address of person who completed cause	ITTENDING CARDI	Date MARY	LAND 000	41711 FP	eruary 3,	2005	
	ノ		JONATHAN SAFREN M.D.	3449 W12	YENS AM	NUE, Suite 3	SO BALT	imope, mary	AND 21229	
R	State egistra		31. Date filed (Month, Day, Year) 32. Red	Strar's Signature	Said	= 300				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N	<i>l</i> larylan		artment of F		d Mental Hy	giene Reg. No.	005	03468	
		1. Decedent's Name (First, Middle, Last) Physician /Medical CHARLES ALBERT				WEBSTER				2. Date of Death Month JAN 30 20		3. Time of Death P M	
	Examin		4a. Facility Name (If not institution, give NATIONAL NAVAL		4b. City, Town, or Location of Death BETHESDA			eath	4c. County of Death MONTGOM		MERY		
	Funeral Director		317-12-3434 -	ox 7. / OXM 2□ F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			th y, Year) 192	9. Birth Cou 3 INDI	place (State or Foreign ntry) ANA	
Maryland 2121	e Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	th with th	al Director									ntry?		
	irs after dea of, or Items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1X Yes 2 [If Yes, Give Year or Date:	s? ⊒No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 為\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		14. Race - Ameri Black, White, Specify: WHI	etc.	
	be tiled within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Items 23a or 28a-1 ehow event, the Medical Examinat must be multiked at	Completed								6b. Kind of Business/Industry			
	be tiled value Hygie	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mai						Maiden	•			
	s 1 and 2 should be f Health and Mental item 27 Is marked other traumatic ev	10	CLYDE RECTOR WEBS	ype, Print)				and Number or	Rural Route Numbe	ər, City o		o Code)	
		1 100	JO ANN C. WEBSTER 20a. Method of Disposition 1 Burial AXCremation 3 Department of Disposition	Removal from Sta	te C	Place of Dispo emetery, crem	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or To		
Baltimore,	permit. Page Department of Importent: If any injury or once.		14 □ Departion 35 □ Other (Specify) NATIONAL CREMATORY FEB 4, 2005 FALLS CHURCH, VA 21. Synature of Fineral Service Licensee 22. Name and Address of FacilityDEMAINE FUNERAL CHAPEL 5308 BACKLICK RD. SPRINGFIELD, VA 22151										
ilvision of Vital Records, P.O. Box 68760,	Physician		23a Part 1. Enter the disease of comy shock, or heart failure. Last only Immediate Cause (Final disease or condition	plications that cous one cause on each	i line.	h. Do not ent		ig, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): CARCINOMA OF THE LUNG									
	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, It any leading It immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to [or a	as a consequ								
	the death certific y the attending p iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 Fetal	l death 3	Ectopic pregnancy Other (specify)	1		2	23d. Date of deliv Month	ery Day Year	
	w requires that been signed b should be dete	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca								of tobacco use contribute to the cause of death? Yes 2 XNo 3 Probably 4 □Unknown		
	(Q	Completed						1	24a. Was autop perio 1 X Yes		24b. Were auto prior to co death? 1 \(\sum \text{Yes}	ppsy findings available impletion of cause of	
	nysician: his certific director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	26. Place of Death (Check only one)							3 ☐Other (Specia	(y)	
		atlon:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? on M 1 ☐ Yes 2 ☐ No				28d. Describe l	8d. Describe how injury occurred				
	P di i	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or within 24 hours after To the Funerel Dir completely tilled in	Medical (29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
)	To the within 2 To the complete		29b. Signature and title of certifie	Teta 1	ho		29c. Licens 01012	e number 35236 (e signed (Month,		
Ü	Gen Len		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTIL										
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regi	střar's Signa	iture	_	لالإشانة بديد	110 2000	0,0			

DHMH 17 Rev 1/2001

dΙ			1- State Unpend Item Registrar	State of Maryl 23a,27,28a-f	and/Depa per me	artment of H	lealth and N	Mental Hygi	ene	
	hysici Medic		Decedent's Name (First, Middle, Las EVA WHITE			unodio or i		2. Date of Death Month Febraury	Day Yea	M
	xamir		4a. Facility Name (If not institution, give University of Mar	yland Hospit		4b. City, Town, or Baltimor	Location of Death		4c. County of De	
Dir	neral ector		5. Social Security Number 6. Security Number 185–56–1504 Usual Residence of Decedent	□M 2STF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 12-25-19	rear)	Birthplace (State or Foreign Country) HILADELPHIA, F
Maryland	filed at	tor	10a. State 10b. County PA. DAUPHIN	10c	. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
ath with the M	ust be not	Funeral Director	10e. Street and Number 146 LINCOLN ST.	•		10f. Zip Code 17113		100	g. Citizen of What USA	Country?
d 21215-0036 filad within 72 hours after death with the Maryland Hygiana.		þ	11. Marital Status 1 ☆ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	
21215-003 id within 72 hours	ne Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired,	luring most of work	king unk	6b. Kind of Busines	ss/Industry unk
Maryland 2 d 2 should be filad th and Mental Hygi	other traumatic avant, IL & Ma	To Be Co	17. Father's Name (First, Middle, Last) EDWARD BRADLEY					e (First, Middle, Ma	aiden Sumame)	
e, Mar l and 2 sho lealth and	her traum		19a. Informant's Name/Relationship (7) JEANETTE WILBERN	(MOTHER)	1915	PENN ST.	HARRISBU	RG, PENNA	17102	
Baltimore, parmit. Pages 1 av Department of Hea	njury o		20a. Method of Disposition 1 Surial 2 Cremation 3 1 1 Control 1 C	Removal from State	LLIAM HO	natory or other place WARD DAY	2-8-2	.005 ST	EELTON,	PENNA
Balti parmit. Departr	any ir		21. Signature of Funeral Service Ligaria 23a. Part1. Ser the disease, or comp	J. AKIB	20 7	04 N. FRO	NT ST. S	TEELTON,	PENNA 17	NERAL HOME, IN 113 Approximate
68760, West included and polysician	dical inner transit	edical Examiner	shock, or heart failure. List only of limmedials ause (Final disease or or ndition resulting a death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.) Due to (or as a const.) Due to (or as a const.)	sequence of):	ounds wit	h compli	cations		Interval Between Onset and Death
I Records, P.O. Box (The law requires that the death certif	detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes	23c. If yes, outcome of pre 1☐Live birth 2☐F 4☐Pregnant at time o 9☐Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day Year
cords, P.	d be d	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause give	n in Part I.			to the cause of death?
Vital Recicion: The law	page 2	e Completed	25. Was case referred to medical				26 Place of Death	24a Was an autopsy performed Yes 2 Check only one)	d? prior to	
Division of or Attanding Physiter death. Director: After this	funeral di	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	dospital: 1 ☑ Inpatient 2 28a. Date of Injury (Month, Day Year, 6-24-02 28b. Place of Injury - Abuilding, etc. (Spethome	5:06 I	3 DOA Other 28c. Injury Work? 1 Y	4 Nursing Horat	me 5 Residence 28d. Describe how in	injury occurred	Bural Route Number,
To the Hospital within 24 hours a	completely filled in by	Medical	one 2 Madical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.	knowledge, death ination and/or inve	estigation, in my opi	e, date and place, a nion, death occurre	and due to the cause	o(a) and manner a	o stated
Towith	СОЛ	2	29b. Signatule and title of certifier	M		29c. License	number		Date signed (Mon	
<i>i</i> D.	Stat		30. Name and address of person who at 200 and 31. Date filed (Month, Day, Year)	32. Registrar's Sig	11	*	reet Bal	timore, M		
. He	egistra		FEB 0 7 2	UUD MARKEN	No fresh					

			For State Registrar	State of	Maryland		artment of F tificate of		Mental Hygi Re	ene g. No. 005	03470
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of Death Month	Day Year	
	/Medio	cal	MIRIAM 4a. Facility Name (If not institution)	, give street and num	ber)	W	ILLEN 4b, City, Town, o	r Location of Death	FEBRUARY	4c. County of De	8:40 A M
	LXaiiii	ic.	HOSPICE OF BALT	TIMORE GIL	CHRIST	CTR.		TOWSON		BAL	ΓIMORE
	Funeral Director		5. Social Security Number 215-07-7297	6. Sex 7	. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, APR. 7, 10	9. B	rthplace (State or Foreign country) MD
ī	pug A		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				10d. Inside City Limits
	Manyla 1 sho	tor		LTIMORE	100. 01.9		GS MILLS				1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28e-f show rmat be notified at	Director	10e. Street and Number	_ I I I I I I I I		OWIN	10f. Zip Code		10	g. Citizen of What C	country?
	23a o	al D	4730 ATRIUM CO	OURT #325				21117			USA
	er de	Funeral	11. Marital Status	12. Was Deced	ces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
0036	be filed within 72 hours after death with the Marylan ital Hygiene. id other than "netural", or Items 23a or 28e-1 show event, I'ra Madical Evantrar mart te nutified at	by	1 ☐ Never Married 2 💢 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Dat	tes:		1□Yes 2\No	Specify:		Specify:	WHITE
2-C	72 hc	eted	15. Decedent (Specify only highes	's Education it grade completed)		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wor	king	6b. Kind of Busines	s/Industry
7	within iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		OO NOT use retired VISTRATOF			STATE GOVE	ERNMENT
פר	be filed tal Hygie d other event, II	Be C	17. Father's Name (First, Middle, I	Last)					ne (First, Middle, M		
yıaı	2 should be and Mental is marked o	ToE	HARRY			KESSI		CELIA			SELENKO
Mar	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationsh MARTIN WILLEN							City or Town, State,	,
ค์	s 1 and 2 f Health item 27 i	1	20a. Method of Disposition			ace of Dispo	sition (Name of			Oc. Location - City o	
аппо	Page: nent o nnt: If iny or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from Si pecify)	tate		natory`or other plac I ENDSH I P	1	2005	BALTIMORE	. MD
galti	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Signature of Funeral Service I	Licensee		22	. Name and Addres	ss of Facility SO	L LEVINSO	N & BROS.	, INC.
	40200		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the death.				7-00		MD 21208 Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on ea	ch line.		ren				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a Due to (o	r as a consequ				early		Merrica
	LAGIIIIICI	e.	Sequentially list conditions, if any, leading to immediate	b	r as a consequ	ence of):					
	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
,00/	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (o	r as a conseque	ence of):					
20/2	ficate be physicials the bur	edical		d							
XO		In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	ome of pregnan		Ectopic pregnancy			23d. Date of de	livery
ם כ	The law requires that the death certifite has been signed by the attending sage 2 should be detached for use a	Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nt at time of de		Other (specify)			Month	Day Year
r.	s that t ned by e detac	by Ph	Part II. Other significant conditio	/	1					cco use contribute t	o the cause of death?
ecords,	equire en sig ould b	ted b	Caronmy	INTERY (LISEA	se,	recent	mycen	der (1 Yes	2 2 No 3 □ P	robably 4 Unknown
) (4)	ne law r has be ge 2 sh	Completed	infaction	, obsm	otro	e Lun	g dise.	456	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
VII		e Co	25. Was case referred to medical					26. Place of Dog		No 1 ☐ Ye	s 2 No
>	nysicie nis cer direct	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inj	patient 2 E	R/Outpatien	3 DOA Oth	ar		ice 6 Other (Spe	ecity) Hospice
5	ing Ph		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how	v injury occurred	
VISION	uttend death ctor: / y the f	ertification:	2 Accident investig 3 Suicide 6 Could n	not be 390 Place of	of Injury - At hor	ne. farm stre	M 1 D	Yes 2 □ No	28f Location /Stre	eet and Number or R	Tural Route Number
2	s after s after st Dire	Certi	4 Homicide determi		g, etc. (Specify)		out addity, office		City or Town,		ara riodic ridinesi,
	To the Hospitel or Attending Physicien: white 24 hours after deals after deals. To the Funerel Director: After this certifies completely filled in by the funeral director;	edical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the b Examiner: On the bas and manner	is of examination	viedge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	\wedge	17		29c. License			d. Date signed (Mon	
			If Hatt	my Re	les,	und	023	5205	t	ebrua	my 2,2005
	17		30. Name and address of person v	who completed cause	of death/(Item	23a) (Type, 1	1 N.CU	harles S	7. Bal	to Md 2	ny 2,2005
	Sta		31. Date filed (Month, Day, Year)	32.	gistrar's Signatu	ire	- 40 6			-	
	Registr	ar	FFR 0.7	2005	EURI K	1. 100					

1 tebruary 2, 2005 at 840 Am

			For State Registrar	State of M	larylan	-	artment of F rtificate of		d Mental Hy	giene Reg. No	2000	031.71
			1. Decedent's Name (First, Middle	Last)					2. Date of De			3. Time of Death
	Physici /Medio		CLARENCE VE	RNON ASHL	EY				Inver	1 19	y Year	5 14 45 PM
	Examir		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of De		40	. County of Deat	th
			Washington Co.	Community H	ospit	al	Hager	stown		İ	Washing	ton
	Funeral			6. Sex 7. A		ast birthday)	If Under 1 Year Months Days	If Under 24 H	lin (Month, Da	av. Yearl	9. Birt	hplace (State or Foreign
	Director		219-60-1963	1 ⊠ M 2□F	50	Yrs.	24,0		04-26-	1954		ryland
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	l sho	5										1₽Yes 2 No
	28a-	Director	Maryland Kent 10e. Street and Number		_ Ci	hester	10f. Zip Code		1	10g Ci	tizen of What Co	ountry?
	with March			Design			21620			-	JSA	,
	d within 72 hours after death with the Maryland jiene. I than "netural", or Items 23a or 28a-f show If to Mudical Exama ar must be multified at	Funerai	203 Lincoln 11. Marital Status	Drive			Was Decedent of I	lispanic Origin?	(Specify Yes or No		14. Race - Ame	nican Indian,
	r Iten	표	1 Never Married 2 Marrie	Armed Forces ad 1 Yes 2 1	? [No	'	f Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, Whit	e, etc.
ဗ္ဗ	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	•		1 ☐ Yes 2 ☐ No	Specify:			Specify:	ack
21215-0036	72 ho netur	Completed	15. Decedent' (Specify only highes		1	16a. Deced	lent's Usual Occup	pation	undeina	16b. K	and of Business/	
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		Co	12			Print	ing Mach				esapeake	Publishing
p		Be	17. Father's Name (First, Middle, L	ast)					Name (First, Middle		Sumame)	
<u>ya</u>	should be ind Mental la marked o	은	Clarence	Ashley				Thelm		at		
Maryland	2 sh and lam raum		19a. Informant's Name/Relationsh						Rural Route Numb			
	1 and 1 and 1 ealth em 27 ther to	3	Thelma Deato	n / Mother	20h PI		Lincoln sition (Name of	Drive,	Chesterto Date		lary Land ocation - City or	
Baltimore,	8 = 0		1 🕱 Burial 2 ☐ Cremation		, ce	emetery, cren	natory or other pla	· 1				
Ë	t. Partmer		`4 □Donation 5 □ Other (Sp		Jan	e's UM	Church	Cem. 01	- 25 - 05			,Maryland
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Fineral Service L	Xwice)	22	Bennie S Road 298	mith Fu , Chest	neral Hom ertown,Ma	ie iryla	and 2162	20
			23a. Park. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death							Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as	s a consequ	ence of):						15 7
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Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to lo	s a consequ	ience of);						
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9		/Me	IF FEMALE:	22a If you guitoom	o of progner	201						
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy	у			23d. Date of deli Month	ivery Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time or de	ratin 5 L.	Other (specify) _	,				
٥.	that the	Ph	Part II. Other significant condition	s contributing to death	but not resu	Iting in the un	iderlying cause giv	en in Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
ds,	sign d be	d by	-				, , ,		10	Yes 2	□No 3□Pr	obabiy 4 EUnknown
Record	w requir been si should	ompleted							24a. Was		24h Wasa au	tages findings available
že	has e 2	ш							- autor		prior to death?	topsy findings available completion of cause of
		O							1 ☐ Yes	2 TNo		2 No
of Vital	Phyalcian: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		-B(0	3CI DOA Ott	000	Death (Check only o		. 704	
	Phys rthis raldi	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury		ER/Outpatient 28b. Time of	JU DOX	4 [] (4013)(1)	Home 5 Resident			city)
Division	ding Ph th. After thi funeral	tlon	1 Natural 5 Pending 2 Accident investig	(Month, Da	ay Year)	Injury	28c. Injur Wor M 1 🗆	rk? Yes 2 ☐ No		,-	,	
2	or Attending after death, Director: After in by the fune	fica	3 Suicide 6 Could no	ot be 28e. Place of In	jury - At ho	me, farm, stre	eet, factory, office	7.00 - 100 AV	28f. Location (Street an	nd Number or Ru	ıral Route Number,
á	after after Dire	Certification:	4 Homicide	building, e	tc. (Specify,)			City or To	wn, State)	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical 5	Physician: To the best xaminer: On the basis	of examinati	vledge, death ion and/or inv	occurred at the timestigation, in my control	me, date and pla ppinion, death oc	ace, and due to the courred at the time,	cause(s)	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner s	ialed.		29c. Licens	se number		29d. Dat	te signed (Month	n, Dav. Year)
	Z × Z				>		_	523			121/0	
				m 8-5	doath (tr	22a) (T: '		0 63		`	/ - 1/0	•
			30. Name and address of person was Dr. Khalid M.	77 1	126 0.	1 Co	unt Una	erstown	.Marvland	217	40	
	Sta	te.	31. Date filed (Month, Day (M)	O 20052. Regis	ar's Signat	ure	are, mag	CLUCUMII	, y a	/	• • • • • • • • • • • • • • • • • • • •	
	Registr	ar	JAM	0 2003	A JARLA	J.	Aporte)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan. 21, 2005 Physician Mary C. Anders 0040 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Hospital If Under 24 Hrs. 6. Sex Birthptace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 95 Days Hours 1 □ M 2 □XF 215-26-1046 Oct. 11, 1909 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County r then "natural", or items 23a or 28a-f show the Medical Example of thest be notified at Rockville Md. Montgomery 1XYes 2 No Director 10f. Zip Code 2 0 8 5 0 10g. Citizen of What Country? 10e, Street and Number 9701- Veirs Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filled within 72 hours efter nent of Health and Mental Hygiene. snt: if item 27 ie marked other then "natural", or ite 1 XNever Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) College (1-4or 5+) Elementary/Secondary (0-12) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry E. Anders Bertha R. Anders 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

Ms. Christie Hughes-Executor-9701-Veirs Dr., Rockville, Md. 20850 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Trinity Luth.Cem. 1/28/2005 Taneytown, Md. pernit. Page Department of Importent: if any injury or page. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St., NW, Wash., DC 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumoni Sequentially list conditions, if any, begins to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No this certificete has been signed by the all director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 410 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 THO 1 Ampatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident i or Attanc etter death i Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitai or within 24 hours eff 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6181 Chin 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 25 700F Characholon 9901 Medeal Center Drive Rockville, MD 32. Registrar's Signature State Registrar

		4 Chata	epartment of Health and M Certificate of Death	lental Hygie	-	0347
Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Allen 4a. Facility Name (If not institution, give street and number)		2. Date of Death Month Jan 1	9 2005	
Examir Funeral Director	ier	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth Month Day May I	Prince 9. Bin 2 Nor	
the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Prince Maryland George 10c. City, Town River		100	J. Citizen of What Co	10d. Inside City Limit 1 X Yes 2 □ N
within 72 hours after death with the Maryland jien. Jien. The Medical Examination Inditional to Inditional	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 14 Yes, Give Year or Dates:	20737 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:		U.S.A	nican Indian,
d within giene. ir then	Completed	(Specify only nignest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired) rsing Aid	ng	Bb. Kind of Business/Private	Industry
should be filed and Mental Hygi marked other umatic event, ii	To Be C	17. Father's Name (First, Middle, Last) Joseph Watkins	18. Mother's Name	e Thorn	ton	Tin Code ¹
ges 1 and to f Heal		Shelia Y. Doggett, daughter 56 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of I cemetery.	06 60th Aveune, Disposition (Name of crematory or other place)	Riverdal Date 20	le Mary1 c. Location - City or Brentwo	and 2073 Town, State
permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee	22. Name and Address of Facility HAI 621 Florida Avent	LL BROTH	HERS FUN Washing	
Physician /Medical Examiner popularitansi	il Examiner	if any, leading to immediate Due to (or as a consequence of	ular accident rotic disease	r respiratory arrest		Approximate Interval Between Onset and Death
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delin	very Day Year
w requires that been signed by should be deta	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the CONONARY ATTEMPT DISCUSSES	he underlying cause given in Part I.		cco use contribute to	
ilcian: The law r certificate has by rector, page 2 st	e Comple	Sacral decubitus ulcer 25. Was case referred to medical			prior to c	opsy findings availab ompletion of cause of 2 No
Phys this al dii	Certification: To B	examiner? 1	ne of 28c. Injury at 2 ury Work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	The state of the s	e 6 ⊡Other (Specinjury occurred	ify)
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		4 Homicide determined 256. Place of Injury - At nome, farm building, etc. (Specify) 29a. Certifier Physician: To the best of my knowledge of	feath occurred at the time, date and place, a	City or Town, S		
To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	to the cause(s)
Star Registra		30. Name dress of person who completed cause of death (Item 23a) (T) 606 Hammonds Lane Suite (31. Date filed (Month, Day, Year) 32. Registrar's Signature	-2 Brooklyn Park	MD Ziz	25	

DHMH 17 Rev 1/2001

ORIGINAL

			riease	Object of Manual and	d (De	idelible lik	Lisale A	Mastellia	Are Legible	•
			For State	State of Marylan	a / Dep	artment of l ertificate of	Health and			5 03474
			Registrar 1. Decedent's Name (First, Middle, Las	*)			Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an		^ Abdell	-+: <i>-</i>			Month	17/2005	
	/Medic		Helmy 4a. Facility Name (If not institution, give		atii	4b. City. Town.	or Location of Dea		4c. County of D	
	Examin	er	Shady Grove I			Rockvi			Montgo	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday,	If Under 1 Year	If Under 24 Hr			Birthplace (State or Foreign Country)
	Director		578-19-8910	X ^{M 2□ F} 47	Yrs.	Months Days	Hours Min	11/25	5/57 Ec	rypt
Т	p ,		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or L	ocation				10d. Inside City Limits
	shov	5	,		,	DOMINOT				1 ☐ Yes 2X No
	he M	ecto	Md. Montgom 10e. Street and Number	ery Pot	comac	10f. Zip Code			10g. Citizen of What	Country?
	with a or	급		~		208	5.4			Country.
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Escriper rust by Indillian at	Funeral Director	7859 Scotland D	12. Was Decedent Ever in U	.S. 13.			Specify Yes or No- rto Rican, etc.)	Egypt - 14. Race - A	merican Indian,
0	r Iter	Fun	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 X No				rto Rican, etc.)		hite, etc.
3	ral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify: I	Black
ה ה	72 honatu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of we	orking	16b. Kind of Busine	ss/Industry
2	Mithin her.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	l		9d)		Embacev	of Egypt
N .	filed v Hygie other t		12. 17. Father's Name (First, Middle, Last)		Driv	ver	18. Mother's Na	me (First, Middle	Maiden Sumame)	Or Egypt
ă	0 = 0 >	Be c		ו - ד י ב					•	
Maryland 21215-0036	2 should be and Menta is marked	2	Makkawy Abdel 19a, Informant's Name/Relationship (1)		19b. Mail	ing Address (Stree	Halim of and Number or F		er, City or Town, State	e, Zip Code)
<u>8</u>	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.		Amel Bashir/ w	**					ac, Md.	
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	20b. F		osition (Name of ematory or other pla		Date	20c. Location - City	
Ē	Page Page 7.7. = 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify					/18/05	Suitlan	d. Md.
Baltimore,	mit.		21. Signature of Funeral Service Liger		2	2. Name and Addr	ess of Facility U	niversa	l Mortua	rv
Ö	permi Depar Impor any ir		Josep 11	lat	- 2	111 Kem	nedy St	.,N.W.	Wash.,D.	C. 20011
	9876		23a. Part 1. Enter the disease, or com- shock, or heart railure. List only	olications that caused the deat						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. gastroint	estin	al h	emorrh	wage		Onset and Death days
	/Medical		resulting in death)	a to (or as a conseq		-		J		J
	Examiner		Sequentially list conditions.	b						
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
	ecute and I-tran	xar	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):					
760,	ficate be executed physician and is the burial-transit	calE								
687	icate phys s the	-		d						
ŏ	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of	delivery
ă	death e atte	iciai	in the past 12 months?	1□Live birth 2□Feta 4□Pregnant at time of c		□Ectopic pregnand □ Other (specify)			Month	Day Year
o.	that the de ed by the a detached f	hys	9 Unknown	9□ Unknown						
ري ص	The law requires that the death certifica ite has been signed by the attending phoage 2 should be delached for use as th	by P	Part II. Other significant conditions of		ulting in the	underlying cause g	iven in Part I.			to the cause of death?
ğ	w require been sig should b	ed	Hepatitis C					101	Yes 2 UNo 3	Probably 4 Unknown
Records,	law re as be 2 sho	Completed						24a. Was autop	osy _prior	autopsy findings available to completion of cause of
ř		Com						perfo 1 ☐ Yes	ormed? death	
ıta	sician: The law scertificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?					eath (Check only o		
	ding Physician: After this certification of the director, the second director director, the second director director, the second director director, the second director director, the second director director, the second director director, the second director	T _o	1 Yes 2 No	Hospital: Impatient 2		ent 3 DOA	ther: 4 Nursing		dence 6 Other (S	(pecify)
חמ	iing Phys J. After this funeral di	ion:	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	uryat ork? ∐Yes 2∐No	28d. Describe r	how injury occurred	
Division of Vital	tence leath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not b		ome farm s			28f Location (5	Street and Number or	Rural Route Number,
\leq	l or Attendatter death Director:	ertif	4 Homicide determined	building, etc. (Special	(y)	tieet, factory, office	,	City or Tox		rialarriodio rialibos.
	spltat ours ours neral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, dea	th occurred at the	time, date and plac	e, and due to the	cause(s) and manner	as stated.
	24 h 24 h e Fur	edicai		niner: On the basis of examina and manner stated.						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	₩	29b. Signature and title of certifier				nse number	1	29d. Date signed (Mo	* '
			> Alicia	7. Mistry	MD	D	59738	-	January	17,2005
	5		30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре	, Print)		0-	ochuillo	MD 20850
			Alicia T. M	istry 9901			enter l	mue 12		20030
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	parte				
	01-401-31		. IAASU 61 /	uu.i # 1000/00/168.3/ /						

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State of Maryland / Department of Health and Mental Hygie	ne	n	n	5		1
Cortificate of Dooth	li-su	6	U	W	1	6

	1 - For State Registrar	State of M	laryland /	Depa Cer	irtment of H	lealth a Death	and Menta		ene () ()	5 0	3475
	Decedent's Name (First, Middle,	Last)						e of Death			Time of Death
ian	Ida A	bramowitz					Mo T A N I		19, 200	ear 5	l1:30 F
cal	4a. Facility Name (If not institution,		•)		4b. City, Town, o	r Location o		JAICI	4c. County of		11.30 1
ner		give street and manipor	,		40. Oky, 10mi, 0	POTO			vo. o odnity or		GOMERY
	MANOR CARE 5. Social Security Number	6. Sex 7. A	ge (in yrs. last b	irthday)	If Under 1 Year	If Under 2		e of Birth			(State or Fore
		1□M 2□F	93	Yrs.	Months Days	Hours	Min. (Mo	of Birth oth, Day, Y	(ear)	Country) New J	
	143-07-2868 Usual Residence of Decedent	Λ	93				Jan	21,	1911	Mew D	ersey
	10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. I	nside City Lin
ō	W11 W		Doton							1	□Yes 2√2
To Be Completed by Funeral Director	Maryland Montgo	omery	Poton	liac	10f. Zip Code			100	g. Citizen of Wh		Λ
ă											
Funeral	10714 Potomac Te				208				UNITED		
une	11. Marital Status	12. Was Deceden Armed Forces	?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Orig in, Mexican	nn? (Specify Ye , Puerto Rican, e	s or No- etc.)		American Ir White, etc.	ndian,
	1 Never Married 2 Marrie	If Yes, Give **		1	☐ Yes 2 No	Specify:			Specify:		_
Completed by	3 ₩ Widowed 4 Divorced	Year or Dates:								WHITI	
ete	15. Decedent's (Specify only highest	s Education grade completed)	168	(Give I	ent's Usual Occup kind of work done	durina most	of working	16	6b. Kind of Busi	ness/Industr	у
du	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retired	1)		İ	•	**	
Ö			h	iomer	naker					n Home	е
Be (17. Father's Name (First, Middle, L	•					r's Name (First,	Middle, Ma	·		
10	Reuben	Yolken				F	anny		Tarlof	f	
	19a. Informant's Name/Relationshi	ip (Type, Print)	19	b. Mailin	g Address (Street	and Numbe	r or Rural Route	Number, C	City or Town, St	ate, Zip Cod	(e)
	Nancy Abramowitz	daughte:	r 96	500 \$	Sotweed I	rive,	Potom	ac, M	D 2085	4	
	20a. Method of Disposition		20b. Place	of Dispos	sition (Name of place)	(a)	Date	20	c. Location - Ci	ty or Town,	State
	1 X Burial 2 Cremation		9		, , ,	·	n- 21	2005	E	- Mar	. Tosa -
	 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L 		Cedar		ck Cemete				Emerso		Jers
	21. Signature of Fulleral Service L	Censee		É	DWARD SAC	EL FU	NERAL D	IRECT	ION, IN	C.	AT SENSOR
	ACOUNT				091 ROCK				1110-1-11		
	23a. Part1. Enter the "son se, or o shock, or heart failure. List o	complications that cause inly one cause on each	d the death. Do line.	not ente	er the mode of dyin	g, such as o	cardiac or respin	atory arrest	t,	Inte	roximate rval Between
	Immediate Cause (Final disease or condition	a DEMENTI	Δ							Ons	set and Death
	resulting in death)	-	s a consequence	of):							
	One with the management	h									
Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a consequence	of):							
Examin	cause. Enter Underlying Cause (Disease or in jury that initiated events										
Exa	resulting in death) Last	Due to (or as	s a consequence	of):					-		
cal		d									
₹.		- W									
Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy						23d. Date of	of delivery	
ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal deat		Ectopic pregnancy				Month.		Year
ysıc	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unknown	at time of death	3 🗆	Other (specify)						
P.	Part II. Other significant condition	s contributing to death	but not resulting	in the us	derlying cause can	an in Part I	234	Did tobac	cco use contribu	ite to the ca	use of death
þ	and an other arguments condition	io commoduly to death	out not resulting	ui o uii	autiyiniy cause givi	zamirasti.	256		2 🖾 No 3		
ted							_	1 U 10S	ZIZNO 3		4 LJUNKNO
Completed							248	. Was an autopsy	24b. We	re autopsy fi	indings availa
E							10	performe	d? dea	th? Yes 2	
0	25. Was case referred to medical					26 Place	of Death (Check		J 140 1 LJ	.03 2	-
Ö	examiner? 1 Yes 2X No	Hospital: 1 Inpati	ient 2□ER/O	utnation	3□ DOA Othe	200	sing Home 5[9 6 TO-6-	(Snank)	
-	27. Manner of Death	28a. Date of Inj	ury 28b.	Time of	3 DOA	4 23 1901			injury occurred	ap a city)	
Certification:	1 Xatural 5 Pending	(Month, D	ay Year)	Injury	28c, Injun Work	(?ົ` Yes 2.⊟N			,		
ical	2 Accident investiga 3 Suicide 6 Could no	ot be	dum. As harman d	A				ation /Ca	at and Number	or Dural De	ites Alicente
Ħ	4 Homicide determin	ad 286. Place of in	iju ry - At home, t tc. <i>(Specify)</i>	arm, stre	et, factory, office		City	or Town, S	et and Number (State)	∍ı ⊓urai H0u	π ο τ ν απιρθέ,
	77						1				
cal	29a. Certifier 1 Certifying	Physician: To the best xaminer: On the basis of	of my knowledg	e, death	occurred at the timestigation, in my or	e, date and	place, and due	to the caus	se(s) and mann	er as stated.	Cause/e)
edical	one)	and manner s	tated.		oonganon, mmy op	,	. Scouling at the	, ante, Gale	and place, and	300 10 1110 1	~~~~
Ž	29b. Signature and title of certifier	240			29c. License	number			Date signed (A		
	- Ahar	IVID			Doo	536	15	JA	NUARY 2	υ , 200	15
1											
	20 Maria and distribution	he completed course of	doath (Itam 00-1	(Tun- 5	Driest\						
	30. Name and address of person w	•	,	- , .		D.C.C		364 555		0852	

Registrar DHMH 17 Rev 1/2001

State

JAN 2 1 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	tate of Maryland	d / Depa <i>Cei</i>	artment of I	Health and M Death	lental Hygie	- C. C.	0347	16
	Dhomini		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of 0	Death
	Physici: /Medic		Paul Auerbach					January	21, 2005		A^{M}
	Examin	er	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ath	
			5221 Green Bridge		and bright of a 1	Dayt If Under 1 Year		8. Date of Birth	Howar		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Is	Ven	Months Days		(Month, Day, Ye	ar) C	rthplace (State or country)	_
			217-46-5613 Usual Residence of Decedent	4:	8			Oct 6, 1	956 wa	shington	, DC
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City	•
	Ba-f	ctor	Maryland Howard	Da	yton					1 🗆 Yes	2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?	
	s 23a	rai	5221 Green Bridge				036		USA	adaga ladiga	
	ltem:	Funerai	v ,	Nas Decedent Ever in U.\$ Armed Forces? I □ Yes 2 ☑ No	5. 13.	was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Arr Black, Wh		
5	Irs aff	by F		f Yes, Give A Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White	
21215-0030	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow than Madical Examinar must be notified at	ted	15. Decedent's Education		16a. Dece	dent's Usual Occup	pation during most of work	16b	. Kind of Busines		
7	thin 7 en "n Med	ηpie	(Specify only highest grade co. Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	ing			
7	ed wi	Completed		5+	Elec	trical E			Northrop	Grumman	
	be fill H do of other	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	den Sumame)		
Š	d Mer nark natic	2	Manuel Auerbach 19a. Informant's Name/Relationship (Type,	Orint)	10h Mailir	na Addrace (Stran	Rachel	Cohn al Route Number, Ci	ty or Town State	Zin Codel	
Maryiand	d 2 st th and th and 7 is r				1				ly or rown, state,	210 0000)	
ย์	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show among high yor other traumatic event, the Mudical Examination man be notified at anone.		Dorothy Auerbach/V 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of			. Location - City o	r Town, State	
baitimore,	Se age		1 ☐Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	-	natory or other pla emorial		4, 2005	Olnov M	D	
	artme sortar sortar injur		21. Signature of Funeral Service Licensee	Jaud			ess of Facility Hin	es-Rinald	i Funera	1 Home	
ă	Ped me		along	Dormell				e Ave, Si			20904
8/60,	whysician and hysician and the burial-transit	ai Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one content of the content of	ause on each line.	yeloge uence of):	enous Leu				Interval Betwonset and D	eath
P.O. BOX 68/	at the death certific by the attending p tached for use as	Physician/Medical	in the past 12 months?	If yes, outcome of pregna 11∟Live birth 2 ∏ Fetal 4∐Pregnant at time of de 9⊡ Unknown	death 3	Ectopic pregnanc	cy		23d. Date of do	Ďay Y	ear
	quires that n signed ald be de	by	Part II. Other significant conditions contrib Fungal pneumonia	uting to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc	co use contribute 2 KNo 3 ☐ F	to the cause of de Probably 4 ⊟Ur	
vital Records,	The law requirestee has been single page 2 should I	Completed						24a. Was an autopsy performed 1 Yes 2 X	prior to	autopsy findings a completion of ca s 2 \(\text{No} \)	valiable use of
VIIÈ	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:		0	han	n (Check only one)			
ō	Phys this al di	To I	1 Tes 2 No	8a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 Nursing Ho	me 5X Residence		ecify)	
	ding l	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	ork? Yes 2 \Bo	200, 0000,00 11011	njury occurred		
Division	I or Attending after death. Director: Afte	Certification:	2 □ Suicido 6 □ Could not be	8e. Place of Injury - At ho building, etc. (Specify	me, farm, str			28f. Location (Street City or Town, St		Rural Route Numb	er,
_1	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai Ce	(Check only \(2 \) Medical Examiner:	n: To the best of my known on the basis of examinat	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)	
	ithin 2 tha	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29d.	Date signed (Mor	nth, Day, Year)	
	日本語の		1 1 1 6 V	ens MO		_	1912		1		005
	40		30. Name and address of person who comp	eted tuse of death (Item	23a) (Tyne				Grunn	1 21, 2	
			Judith Karp, MD	1650 Orlea			ore, MD 21	231			
	Sta	ite	31. Date filed (Month, Day, Year)								
	Regist	ar	JAN 24 2005	32. Pegistrar's Signal	J. 19	A Comment					

Marsha Barnes UNK 05-657 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-657		1- For Unpend Item 2	State of Marylan 3a&27 per me	d / Depa G840 e	artment of tillcate	of Health a tas of Death	nd Menta	al Hygien	e . 20	05 r	131,77
Physicia	an	Decedent's Name (First, Middle, Last)	Marsha Bar				2. Da	te of Death onth D	ay '	Year	· 46 P M
/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, To	wn, or Location of			26, 20 c. County o		:46 P "
Funeral Director		379-90-0223	Vania Avenue 7. Age (In yrs. 41		If Under 1	trict He: Year If Under 20 Days Hours	4 Hrs. 8 Da	te of Birth onth, Day, Yea AC 29,		nce Geor ^{9. Birthplace (S Country) Washin}	
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		y, Town or Lo		al Heigh	ts				ide City Limits XYes 2 ☐ No
th with the 23s or 28s	ai Directo	10e. Street and Number 4330 Wills Street			10f. Zip Co	20743		10g. C	itizen of Wh	nat Country? USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the McGral Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2 ☐	nt of Hispanic Origi Cuban, Mexican, XNo Specify:	in? (Specify Ye Puerto Rican,	es or No- etc.)	Black	- American Indi , White, etc. Black	ian,
within 72 ho ene. than "natur he Modicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NDT use	done during most of		16b.		iness/Industry	
wild be filed Mental Hygi arked other attc event.	To Be Co	17. Father's Name (First, Middle, Last) David Lee					Ella E				
and 2 sho laith and 127 is ma er traum		19a. Informant's Name/Relationship (Type Ella Barnes (Moth				Street and Number					
Pages 1. nent of He int: If iten		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, cres Linco	matory or othe	of er place) metery 2	Date 2/7/200			ity or Town, St.	
permit. Departn importa any inju		21. Signature of Funeral Service License	timore	1		Address of Facility ent Town					s, P.A.
Physician			ations that caused the deat e cause on each line. Atherscleroti					ratory arrest,		Interv	eximate al Between t and Death
/Medical Examiner		resulting in death) Sequentially list conditions	Due to (or as a conseq	juence of):							
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t								
physicia physicia the bur	dical	U d									
ath certif	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 SUnknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Il death 3	Ectopic preg Other (spec				23d. Date Mont	,	Year
quires that the de n signed by the a uid be detached f	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cau	se given in Part I.	23	e. Did tobacco		oute to the caus	
sician: The law require certificate has been signector, page 2 should b	Completed						_	la. Was an autopsy performed?	pri	ere autopsy fini ior to completio ath? Yes 2 N	n of cause of
Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 2Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Othor	of Death (Chec		6XXiher	(Specify) at	scene
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		: Injury at Work?	28d. D	escribe how inj			
To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia		reet, factory, o	office		cation (Street a ty or Town, Sta		r or Rural Route	Number,
he Hosp in 24 hou he Funei pletely fill	edicai		ician: To the best of my kno ner: On the basis of examina and manner stated.					ne time, date a	nd place, ar	nd due to the ca	
To the comp	M	29b. Signature and title of certifier	•			icense number				(Month, Day, Y	
		30. Name and address of person who co	mpleted cause of death (Item	т 23а) (Туре,		enn Stree	et, Bal	timore,	Mary	land 2	21201
Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3 2005	2. Registrar's Signa	ature	20						

	an	1. Decedent's Name (First, Middle, Las RICHARD MADISON B								2. Date of Dea Month ANITARY	Day 19, 20	Yeer 05	3. Time of Death 2:45 A
/Medic		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of		ANUAIXI	4c. County		Z.4J A
xamin	er	105 FOX RUN ROAD	3,700, 2,10 , 10,11,20,7				SONVI				QUEE		E'S
ineral		5. Social Security Number 6. Se		e (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	24 Hrs. 8	B. Date of Birl (Month, Da	h		place (State or Forei
ector		213-44-0056	X M 2□F	62	Yrs.	Months	Days	nours		oct. 21	1942	VA	
>		Usual Residence of Decedent 10a. State 10b. County		10c Cib	, Town or Lo	ation							10d. Inside City Limi
aho a a	ō		nve Lo										1 ☐ Yes 2 📆 N
28a-f	Director	MD QUEEN AN	INE S	GKA	ASONVII	10f. Zic	Code				10g. Citizen of	What Cou	ntry?
Sa or		105 FOX RUN ROAD				216					USA		,
item 27 ie marked other than "natural", or itema 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent			Vas Dece	dent of His	spanic Orig	gin? (Spec	ify Yes or No	- 14. Rac		can Indian,
or to		1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ If Yes, Give	№ 196	4-			n, Mexican, Specify:	, Puerto H	ican, etc.)		ck, White,	etc. IITE
Tar.	d by	3 Widowed 4 Divorced	Year or Dates:	197	0	195	ZINO	эреспу.			Specif	y: W.L.	1116
dica	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Deced (Give	kind of wo	rk done d	urina most	of working	g	16b. Kind of B	usiness/In	dustry
than is Mis	dm	Elementary/Secondary (0-12)	College (1-4or 5	5+)	BINDE		se retired)	,			PRINTI	NC.	
theri		9 17. Father's Name (First, Middle, Last)			DINDE			18. Mother	r's Name ((First, Middle,	Maiden Suman		
0 0 0 0	o Be	MASON F. BROWN									INVILLE		
mari	၉	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address	(Street a				er, City or Town,		Code)
27 le		JOSEPH E. BROWN/I	BROTHER					OAD,	GRASC	NVILLE	, MD 2	1638	
item othe		20a. Method of Disposition		20b. P	lace of Disposemetery, crem RYLAND METERY	sition (Name	me of other place	9)	Da	ite	20c. Location -	City or To	own, Slate
Important: if if any injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		MAI CEN	RYLAND ÆTERY	VETE	RANS	0	1/21/	2005	HURLOC	K, M)
porte y inju		21. Signal Te Funeral Service Licens	See ()	1	22	Name ar	nd Addres	s of Facility		e Mizira	AM TELEVIS	DAT II	OME DA
E & 8		Cal 4. 9	4/6	سر	* 10	6 SH	AMROC	K ROA	AD, C	HESTER	MD 2	1619	OME, P.A.
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cian		Immediate Cause (Final disease or condition	. Col	ON	ade	NOCE	cei	noma					Onset and Death
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hed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Ectopic p Other (sp					Mo	onth	Day Year
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al director, page 2	To Be	1 Yes 2 No	29a Date of Inju	v Yeer)	Injury	м	28c. Injury Work 1 □ 1	(? /es 2 □ N		d. Describe i	low alluly occur	160	
funeral director, page 2	To Be	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	, ,									
funeral director, page 2	To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	(Month, Da		nme farm stre	et factor	v office		28	Bf. Location /5	street and Numb	er or Hun	al Route Number.
After this certificate hes funeral director, page 2	To Be	27. Manner of Death 1 Natural 5 Pending investigation	(Month, Da	ury · At ho	ome, farm, stre	et, factor	y, office		28	Bf. Location (S City or Tox		er or Hur	al Route Number,
After this certificate hes funeral director, page 2	Certification; To Be	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inj building, el	ury · At ho	v) 			e, date and		City or Tov	vn, State)		
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Atter this centificate hes funeral director, page 2	Certification; To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigation 6 Could not be determined	(Month, Da 28e. Place of Injudiding, el	ury - At ho c. (Specify of my kno f examina	v) wledge, death	occurred	at the tim	inion, deat	d place, ar	City or Towned due to the dat the time,	m, State) cause(s) and madate and place, 29d. Date signe	anner as s and due to d <i>(Month,</i>	stated. o the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar # 8 Per fh,pg 1/25/05 Certificate of Death Reg. No. Amended Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 15, 2005 Pauline Branch 3:55 а /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. tast birthday) Funeral 8. Date of Birth (Month, Day, Year) 19279. Birthplace (State or Foreign Country) Min. 1 ☐ M 2 🖾 F Months Days Hours Director 217-30-3149 August11, 1928 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Evant or must be notified at ty Yes 2 No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6408 MacArthur Blvd. 20816 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after ☐Yes 2☑No Yes, Give 11 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: by If Yes, Give Year or Dates: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b, Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Librarian Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Mental P Benjamin Branch Cora Pryor and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 MacArthur Blvd. Bethesda, MD 20816 of Health James Branch/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊈Burial 2 □ Cremation 3 □ Removal from State 70 ŏ permit. Page Department of Important: If any injury or once. Harmony Memorial Pk. Jan.22,2005 Landover, MD * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy St.NW Washington, DC 20011 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.0. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes 2€XNo Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To his funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca

filled in by hin 24 hours a Hospital the within 7 To

> 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/200:

(Check only

29b. Signature and title of certifier

30. Name and address of person who

one)

1/11

completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D42518

29d. Date signed (Month, Day, Year)

January 15, 2005

icia dica		State Registrer Decedent's Name (First, Middle, I	ast)		Ce	rtificate	of D	Death	T	2. Date of Deat	g. No.	2005	3. Time of Death
dice		Annie Reb	· ·	Bowen					ŀ	January		3,2005	5:00 AM
ine		4a. Facility Name (If not institution, g				4b. City, To	own, or l	Location of	1		_	County of Death	
		Crescent Citi	es Cent	er			att			·		Prince	
al or			Sex 1□M 2 2 F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
		197-01-9999 Usual Residence of Decedent		90_	113.					Oct. 10,	191	4 Wash	ington, DC
		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Funeral Director	MD Prince (eorge's	R	iverda	Le							1 Yes 2 No
		10e. Street and Number	1			10f. Zip C				1	0g. Citiz	zen of What Cou	•
	era	4409 East-West		edent Ever in L	IS 13)737	spanic Ori	igin? /Spe	ocify Yes or No-		U: 14. Race - Ameri	SA can Indian
	E	1 ☐ Never Married 2 ☐ Married	Armed Fo	orces? 2 X No						ecify Yes or No- Rican, etc.)		Black, White,	
	a by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi Year or D			1□Yes 2t	XI No	Specify:				Specify: Bla	ack
	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual kind of work DO NOT use	done du	uring mos	t of worki	ng	16b. Kir	nd of Business/In	dustry
	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		erk	reurea)			I	ent)	of Def	fense
	a	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle, M			
	To B	Samuel Moore						Nan	cy I	vey			
		19a. Informant's Name/Relationship Richard M. Boy		n								Town, State, Zip ID 20706	
		20a. Method of Disposition										cation - City or To	
		1 ☑ Buria 2 ☐ Cremation 3 4 ☐ Denation 5 ☐ Other (Spe	Removal from	State	Place of Dispo cemetery, crea			1	'an			tland, 1	
		21. Signature of Suneral Service Lic		† PIII								eral Home	
		Kalph /1	Which	inn						THE PERSON NAMED IN COLUMN		on, DC	111-250-1714 De-
		23 art 1. Ent., the discuse, or of shock, or yeart failure. List or	mplications that one cause on e	caused the dea	th. Do not ent	ter the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
		Immediate Cause (Final disease or condition		lure to	103/2								Onset and Death
		resulting in death)		(or as a conse			291 2112	- w					
	<u>.</u>	Sequentially list conditions,	b. Dehr Due to	vdratio	n / Der	crease	d Ir	itake					
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		resulting in death) Last		(or as a conse	quence of):								
8	dical		d. Hyp	ertensi	ch								
-	Physician/Med	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancy							3d. Date of delive	env
	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√3/No	4☐Pregi	birth 2 ☐ Fet nant at time of		Ectopic pred Other (spec						Month	Day Year
	hys	9 Unknown	9□ Unkn	iowπ									
	by P	Part II. Other significant condition:	-	leath but not re	sulting in the u	nderlying cau	use givei	n in Part I.					he cause of death?
	ted	Pressure Ulce	rs							1 🗆 Ye	s 2-6	No 3 ☐ Prot	bably 4 □Unknown
	ompleted									24a. Was ar autops	У	24b. Were auto prior to co death?	opsy findings available impletion of cause of
١	O									perform			2 No
	o Be	25. Was case referred to medical examiner?	Hospital:	Innationt 2	TER/Output		Othou			(Check only on			
	- 1	1 ☐ Yes 2 🛣 No 27. Manner of Death		Inpatient 2 of Injury oth, Day Year)	28b. Time o		c. Injury Work	42 140		ne 5∟ Heside 28d. Describe ho		Other (Specif occurred	fy)
ļ	atlo	XXNatural 5 Pending 2 Accident investigat		ith, Day Year)	Injury	М		? 'es 2 🔲 i	No				
		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	286. Place	e of Injury - At h	nome, farm, str	reet, factory,	office		2	28f. Location (Sti City or Town		d Number or Rura	al Route Number,
	ti ti												
	Certification:			e best of my kn	owledge, deat	h occurred at	t the time	e, date an inion, dea	id place, a ith occurri	and due to the ca	use(s)	and manner as s	tatad
		29a. Certifier 1	Physician: To the aminer: On the b and man	pasis of examin	ation and/or in	vestigation, i	ii iiiy opi	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ad at the time, do	ite and	place, and due to	o the cause(s)
	Medical Certiflo	(Check only 2 Medical Ex	aminer: On the b	pasis of examin iner stated.	ation and/or in		License					place, and due to e signed (Month,	o the cause(s)
	edical	(Check only 2 Medical Ex	aminer: On the b	ner stated.		29c.	License	number		29	d. Date	place, and due to	o the cause(s) Day, Year)
	edical	(Check only 2 Medical Ex	aminer: On the band man	H-YS/C/	AIV	29c.	License	number		29	d. Date	place, and due to	o the cause(s) Day, Year)
	Medical	(Check only 2 Medical Exone) 29b. Signature and title of certifier	aminer: On the band man	H-YS/C/	月 / V m 23a) (Type, / () を / Y	29c.	License	number		29	d. Date	place, and due to	o the cause(s)

DHMH 17 Rev 1/2001

Registrar

		1- State of Maryland /	•	tment of Health and ificate of Death		2005	031.82
		Registrar 1. Decedent's Name (First, Middle, Last)		meate or Beatin	2. Date of Dea		3. Time of Death
Physic /Med		AARON BUNDICK			JANUARY	Day Year 7 2005	23:54 PM
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D	eath	4c. County of Dea	th
- N		FT. WASHINGTON HOSPITAL		FT. WASHINGTON		PRINCE GE	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 1 ☑ M 2 ☐ F 49			Min. (Month, Day	r, Year) Co	thplace (State or Foreign ountry)
		Usual Residence of Decedent			August	18 1955 VI	RGINIA
arylan show	.	10a. State 10b. County 10c. City, Tow	wn or Loca	ation			10d. Inside City Limits
he Me	Director	MD PRINCE GEORGE'S FORT W	VASHI				1⊠Yes 2□No
ath with the Maryla 23s or 28e-f show		10e. Street and Number		10f. Zip Code 20774		10g. Citizen of What Co	ountry?
death with the Maryland ms 23s or 28e-1 show Listst be ristlifted at	Funerai	6235 PIMRILL COURT 11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No-		
after dea or items	F	1 Never Married 2 Married Armed Forces? 1 Styse 2 No		Yes, specify Cuban, Mexican, Pi □ Yes 2⊠ No — <i>Specify:</i>	uerto Rican, etc.)		
15-UU36 72 hours after de "neturel", or items	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					31ack
1215-UU36 vithin 72 hours af ne. han "neturel", or e Medical Exerci-	Completed	(Specify only highest grade completed)	(Give ki	nt's Usual Occupation ind of work done during most of O NOT use retired)	working	16b. Kind of Business	Industry
ZTZTS Swithin 72 Jiene. r than "m	omo	Elementary/Secondary (0-12) College (1-4or 5+)		ator Operator		Gover	nment
ING 21215-UU36 be filed within 72 hours after tal Hygiene. d other than "neturel", or ite event, ITE Madical Examinis	e	17. Father's Name (First, Middle, Last)			Name (First, Middle,		
faryland 2 should be and Mental Is marked o	10	Fred Bundick			n Parker		
Maryland d 2 should be file th and Mental Hy 7 Is marked oth treumatic event		1 1 21 1		Address (Street and Number of Eastern Ave. N.			, ,
e, R 1 and 1 and Health iem 27	1	20a Method of Disposition 20b. Place of	of Disposit	tion (Name of		20c. Location - City or	
Baltimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other treumatic e		1 Burial 2 □ Cremation 3 □ Removal from State cemete		Rtory or other place) Veterans 1/2		heltenham,	
Baltimore, permit. Pages 1 ai Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Consee		Name and Address of Facility			
n aalia		16 6	74	74 Landover Roa	ad Landove	r, Marylan	1 20785
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter	the mode of dying, such as car-	rdiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death) a. Sudden Card resulting in death)		Death			Oriset and Death
/Medica Examine		Due to (or as a consequence		The second			
A.*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause, Disease of injury		Disease			
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60, be executed ician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence	e of):				
8/60 cate be e chysician the buris	dicai	d				-	
Hecords, P.O. Box 68/ The law requires that the death certificate are has been signed by the attending phys age 2 should be detached for use as the	a a	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	iverv
death cer a attendin d for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)		Month	Day Year
at the de stached betached	hys	9 Unknown					
S, F	þ	Part If. Other significant conditions contributing to death but not resulting	1	lerlying cause given in Part I.		bacco use contribute to	
Hecords, he law requires t e has been signe sge 2 should be o	Completed	Anemalous right Coronary Art	Lery				obably 4 □Unknown
The law rate has be page 2 s	mpi				24a. Was a autop: perfor	sy prior to	topsy findings available completion of cause of
	e Co	25. Was case referred to medical		26 Place of	1 ☐ Yes Death (Check only or	2 No 1 ☐ Yes	2 🔀 No
r VIta ysicien: is certific director,	0 B	examiner? Hospital:	Outpatient	Other		ence 6 Other (Spe	cify)
On Of ding Phys h. After this funeral dir	n: T		. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
SIOI leath. or: Al	catic	2 Accident investigation		M 1 Yes 2 No			
DIVISION tel or Attending s after death. el Director: Afte	Certification:	4 Homicide determined 28e. Place of injury - At home, for building, etc. (Specify)	farm, stree	et, factory, office	28f. Location (S City or Town	treet and Number or Ru n, State)	ıral Route Number,
UNUSION OF VITA Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certific tely filled in by the funeral director,		29a. Certifier Certifying Physician: To the best of my knowledge	lge, death o	occurred at the time, date and pi	lace, and due to the c	ause(s) and manner as	stated.
ne Ho 24 h ne Fui detely	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	and/or inve	stigation, in my opinion, death o	occurred at the time, d	late and place, and due	to the cause(s)
To the Hospitel Within 24 hours a To the Funerel to	ž	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Mont	h, Day, Year)
(10)		Herman VIST, N	I.D.	20174		January 19,	2005
THE		30. Name and address of person who completed cause of death (1em 23a)		rint) et N.E. Suite]	100 Washin	gton. DC 20	0017
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	٠. م	CC H.H. Darce 1		0.50.1, 50 20	
Regis		JAN 2 5 2005 Been 1	V				

				partment of Health and Mental Hy	ygiene Reg. NS: 005 03483
	Physici		1. Decedent's Name (First, Middle, Last) Aissatou Hadja Bah	2. Date of D Month Jan.	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Springs	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1 M 2CF 7. Age (In yrs. last birthday 65 Yrs.	Months Days Hours Min. (Month, D	irth (24, Year) 9. Birthplace (State or Foreign Country) 19.1939 Guinea
	se Marylend Ba-f show	ctor		Location ersburg	10d. Inside City Limits 1 ∑Yes 2 ☐ No
	eth with the 23a or 2	rai Dire	30 Blazing Star Way	10f. Zip Code 20878	10g. Citizen of What Country? Guinea
9036	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than *natural*, or iteme 23a or 28a-f ehow minportant: if Item 27 is marked other than *natural*, or iteme 23a or 28a-f ehow any joury or other traumatic event, Ira Madical Examination and Dece.	t by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ ▼No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	within 72 ho lene. than natu	Completed	(Specity only highest grade completed) (Giv Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) emaker	16b. Kind of Business/Industry Home
yland 2	buid be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Thierno Madjou Bah	18. Mother's Name (First, Middle Kaissa Kourd	o, Maiden Sumame) Duma
Baltimore, Maryland	1 and 2 shu Heelth and em 27 is m ther treum			ling Address (Street and Number or Rural Route Numb Blazing Star Way, Gail position (Name of Date	thersburg, Md. 20878
Iltimor	artment of lortant: if it injury or o		1 ⊋Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Family	Cemetery 1-23-05 22. Name and Address of FacilityUniversal	Conakry, Guinea
Ba	Depar Import any kr	5	23a. Parl. Enter the disease, or complications that caused the death. Do not en	411 Kennedy St, N.W., V	Wash,D.C. 20011
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Respiratory F Due to (or as a consequence of): Cardiac Arres Due to (or as a consequence of): End Stage Pan	'ailure	Interval Between Onset and Death
68760,	The lew requires that the death certificate be executed sie has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit	edicai	Due to (or as a consequence of): d.		
P.O. Box	that the death certific led by the ettending p deteched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	w requires that been signed b should be dete	þ	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 ▼No 3 □ Probably 4 □Unknown
Vital Rec		e Completed	25. Was case referred to medical	24a. Was auto perfu 1 □ Yes 26. Place of Death Check on	psy prior to completion of cause of death? 2 \textbf{No} 1 \text{ Yes} 2 \text{ No}
Division of V	Attending Phyer death. ctor: After this by the funeral dis	Certification; To B	examinar? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ont 3 DOA Other: 4 Nursing Home 5 Resident 28c. Injury at Work? M 1 Yes 2 No treet, factory, office 28f. Location (idence 6 □Other (Specify) how injury occurred Street and Number or Rural Route Number.
ā	5 € 5 .⊆		29a. Certifier (Check only 29 Medical Examiner: On the basis of examination and/or i	City or To	wn, State)
)	To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	29b. Signature and title of certifier Chrolass Chrolass	29c. License number 20057688	29d. Date signed (Month, Day, Year)
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type SEA SEA SEA SEA SO) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature	N. FREDERICK AVE	, GATTHESRBURG, MD 20877

		1 - For Stete Registrar	State of M	aryland / Dep	artment of Hea	alth and M	ental Hygi	ene 2005	. 00101
		Hegistrar Decedent's Name (First, Middle)	e, Last)		Tillicate of De	aui	2. Date of Death	1. N6_ U U .	3. Time of Death
Physi		Clarks		notein			Month	Day Yea	ır
/Med Exam		4a. Facility Name (If not institution	n, give street and number)	NS TEIN	4b. City, Town, or Loc	cation of Death	Tanucky	18 200- 4c. County of D	0417
		Montgomery Gen	eral Hospita	1	Olney			Montgom	erv
Funera		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)		Birthplace (State or Foreign Country)
Directo		397-12-5822 Usual Residence of Decedent	120 M 20 F	79 Yrs.			06/25/19		isconsin
land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mary I-f sh	to	MD Montgo	merv	Rockville	a				1 ☐ Yes 2X No
C Z IZT 5-UU36 filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show ant, the Madical Examination of the motified and	Funeral Director	10e. Street and Number			10f. Zip Code		109	J. Citizen of What	Country?
th will	aD	16900 Freedom Wa	ay		20853		1	J.S.A.	
r dea	Iner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-	14. Race - A Black, W	merican Indian,
s afte	by Fu	1 Never Married 2 Marr	ried 1 ☐ Yes 2 X f If Yes, Give	No		Specify:	mount, oto.)		
Z I Z I 5-UU36 od within 72 hours af giene. er than "natural", or I're Medical Exami	ed b	3 ☐ Widowed 4 ☐ Divorced		162 Door	dent's Usual Occupation			Specify: W	
in 72 an a	Completed	(Specify only highes	st grade completed)	(Give	a kind of work done durin DO NDT use retired)	n ng most of workin	na l	b. Kind of Busine United S	
I with jiene.	Eo	Elementary/Secondary (0-12)	College (1-4or 5)+)	Scientist				opiel Conv.
	BeC	17. Father's Name (First, Middle,				Mother's Name	(First, Middle, Ma		SPICE CONV.
aryland should be f and Mental H s marked of umatic eve	To B	Charles H. Barr	nstein			Alma Hai	nsen		
Datrimore, Maryland 2.1215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any nitry or other traumatic event, Ira Madical Examinar mant be notified.		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street and I	Number or Rural	Route Number, C	City or Town, State	, Zip Code)
and 2 and 2 salth n 27 l		Beatrice L. Bar	rnstein, Wif		Freedom Wa	ay, Rock	ville, M	aryland	20853
of He Hiter	ï	20a. Method of Disposition 1 Burial 2 Cremation	3 □ Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Da	ate 20	c. Location - City	or Town, State
Pagin Hard		Donation 5 Other (S		Ft. Lince	oln Cremato	ry 01/23	3/2005 B ₁	entwood,	Maryland
Saltimore, Dernit. Pages 1 ar Dep riment of Hea mportant: If item: my njury or other	1	21. Signature of Fineral Service	Licensee T	_	2. Name and Address of		nple Tri		
<u> </u>		- Lyt	Jean We		040 Rockvil				yland 20852
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each in	ne death. Do not en	ter the mode of dying, su	uch as cardiac or	respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a Metas	totic Col	operal Cana	or to b	120		Onset and Death
/Medica Examine		resulting in death)	Due to (or as	a consequence of):			Tell I		7 10(32(1))
		Sequentially list donditions	b. Colore	a consequence of):	er				Tears
ted	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01 as	a consequence on:					
xecu axecu al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
certificate be executed of the physician and use as the burial-transit	cal								
oo/ ifficate g phys as the			1						
BOX OR Bath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7-			23d. Date of d	elivery
. 0 00	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at		□Ectopic pregnancy □ Other (specify)			Month	Day Year
at the de	hys	9 Unknown	9□ Unknown						
- E DH	by F	Part II. Other significant condition	ins contributing to death bu	ut not resulting in the u	nderlying cause given in	Part I.	23e. Did tobac	co use contribute	to the cause of death?
w require been signature							1 ☐ Yes	2 □ No 3 □ I	Probably 4 XUnknown
law r las be	ompleted						24a. Was an autopsy		autopsy findings available completion of cause of
The lav	Con						performed	t? death?	
vital necolus, ilcien: The law requires t certificate has been signe	Be (25. Was case referred to medical examiner?	LIia-i				(Check only one)		
this aldin	2	1 ☐ Yes 2 X No	Hospital: 1 Inpatie		nt 3 DOA Other: 4	Nursing Hom	e 5 Residenc	e 6 □Other (Sp	ecify)
e in india	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Year) 28b. Time of Injury	Work?		3d. Describe how	njury occurred	
Attending rr death. ector: After by the fune	icat	2 Accident investig	ot be One Blace of Init	In. At home, farm, etc.	M 1 Yes		of Location (Ctree	t and bloom have and	2/ 0
l or Attending after death. Director: After in by the function	ertification:	4 Homicide determi	building, etc	iry - At home, farm, str :. (Specify)	еві, тасколу, опісе	28	City or Town, S	tate)	Rural Route Number,
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	0	29a. Certifier 1 X Certifyin	g Physicien: To the best of	f mv knowledne death	a occurred at the time of	ate and place of	od due to the serve	a(e) and masses	to stated
e Ho: 124 h e Fur letely	dical	(Check only 2 Medicel I	Exeminer: On the basis of and manner sta	examination and/or in	vestigation, in my opinior	n, death occurred	d at the time, date	and place, and du	e to the cause(s)
To the within complete the comp	Me	29b. Signature and title of certifier			29c. License nun	mber	29d.	Date signed (Mor	th, Day, Year)
1		P 0 0			44.0.	677 -	440		0
		30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type,	M00060	1727	J*c	inuary 1	2,2005
		Paul Bannen	18111 9	ince Phili	police #	327	Olne	MD 20	8,7005
	ate	31. Date filed (Month, Day, Year)	32. Ragistra	r's Signature	necks 2		7		
Regist	rar	JAN 2	1 2005 Marie	as to M					

				Department of Health and M Certificate of Death		ene 3. No.2 0 0 5	03485
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) Mahlon Dickinson Clements,		2. Date of Death 1 Month 2	3 ^{Day} 200°5°	3. Time of Death 7:30p M
	Examir	ier	4a. Facility Name (If not institution, give street and number) ACORN Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last bin		8. Date of Birth (Month, Day,)	4c. County of Death Talbot 9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	Yrs. Months Days Hours Min.		1920 PA.	itry)
	the Maryla 28a-f ehov	Director	10a. State 10b. County 10c. City, Town Md Talbot Royal 10e. Street and Number 10e. Street and Number		100	J. Citizen of What Coun	0d. Inside City Limits 1 ☐ Yes 25 No
"	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic evant, the Medical Evantral retruit terrollish at	Funeral Dir	Acorn Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21662 13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Americ Black, White,	an Indian,
21215-0036	in 72 hours a "natural", o belical Exam	Completed by	3 Widowed 4 Divorced Year or Dates: WWII 15. Decedent's Education (Specify only highest grade completed)	1 ☐ Yes 2 X No Specify: Decedent's Usual Occupation (dive kind of work done during most of work) life. DO NOT use retired)	ing 16	Specify: Wh	nite _{dustry}
ınd 212	be filed within tall Hygiene. Ind other than "evant, the Med	Be	17. Father's Name (First, Middle, Last)	tail Marine Busin	(First, Middle, Ma		oyed
Maryland	nd 2 should be lith and Mental 27 is marked or r traumatic evi	To.	Mahlon Dickinson Clements, S 19a. Informant's Name/Relationship (Type, Print) Victoria Clements (daughter)	Mailing Address (Street and Number or Rura	al Route Number, (City or Town, State, Zip	
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		1 ☐ Burial 2√Cremation 3 ☐ Removal from State cemeter. '4 ☐ Donation 5 ☐ Other (Specify) Capit	Disposition (Name of y, crematory or other place) ol Crematory 1-24		over, De.	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the dearly. Do not shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility R. Carroll Hurle To a product of the mode of ling, such as cardiac of the mode of ling,			PC 21663 Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	2			Interval Between Onset and Death
	cuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	rf):			
68760,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of d.	f):			
P.O. Box (The faw requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in HTH Coronary Arty &	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
of Vital Records,		e Completed by	25. Was case referred to medical		24a. Was an autopsy performe	d? prior to com	sy findings available opletion of cause of
	Phys this al di	To B	examiner? 1			ee 6 Other (Specify, injury occurred	
Division	after Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, S		
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurred 29c. License number	ed at the time, date	e(s) and manner as stall and place, and due to be Dale signed Month, D	the cause(s)
!	F 3 F 8		30. Name and address of person w o con pleted cause of death (Item 23a) (1	12816		1/24/05	-,, , , ,
	Sta Registr				Md. 21	601	

Matthew Bly Cowdrey 05-0504 1 - For State Registrar

AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Reg. No.

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then *natural', or flems 23a or 28e-f show any injury or other treumetic event, Tre Medical Examinar, just by multiple and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

12-25-0629 ual Residence of Decedent 10b. County	Give street and number) G Flat Land (G. Sex	ge (In yrs. las 20 10c. City,	Town or Lo EASTO	Fai If Under Months cation N 10f. Zip	1 Year Days Code	ınt	er 24 Hrs.	Januar 8. Date of Bir	4c. So	County of Dea OMERSET 9. Bir 84 M	thplace ((State or For AND)	
ig Annemesex River locial Security Number 12-25-0629 ual Residence of Decedent . State 10b. County MD TA . Street and Number 7689 TRED AVON Marital Status 11 Never Married 2 Marrie 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Lie	@ Flat Land (S. Sex 7. Ag 1 ★ M 2 □ F 7. Ag LBOT LBOT 12. Was Decedent Ammed Forces' d 1 □ Yes 2 ★ If Yes, Give Year or Dates: Education grade completed)	ge (In yrs. las 20 10c. City,	Town or Lo EASTO	Fai If Under Months cation N 10f. Zip	1 Year Days Code	Int If Under Hours	er 24 Hrs.	8. Date of Bi	So rth ay, Yearl 198	omerset 9. Bir 34 M	thplace (ountry) RYL/	AND	
According to the content of the cont	LBOT CIRCLE 12. Was Decedent Armed Forces' 1	ge (In yrs. las 20 10c. City, t Ever in U.S.?	Town or Lo EASTO	If Under Months cation	Days Code	If Unde Hours		8. Date of Bi	rth 198	9. Bir	10d. In	AND	
L2-25-0629 Juli Residence of Decedent State 10b. County MD TA Street and Number 7689 TRED AVON Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Lieuteness)	LBOT CIRCLE 12. Was Decedent Armed Forces' d 1 Yes 2 If Yes, Give Year or Dates: Education grade completed)	20 10c. City, t Ever in U.S.	Town or Lo EASTO	cation N 10f. Zip	Days Code	Hours		8. Date of Bi Month D SEPT 22	. 198	34 MA	10d. In	AND	
All Residence of Decedent I. State I. State I. Decedent I. State I. Decedent I. Street and Number I. Street and Number I. Never Married I. Decedent's (Specify only highest Elementary/Secondary (0-12) I. State Individual Companies I. Decedent's Elementary/Secondary (0-12) I. State Individual Companies I. State Individual Com	LBOT CIRCLE 12. Was Decedent Armed Forces' 1	t Ever in U.S.	Town or Lo EASTO	N 10f. Zip	21	.601		SEPT 22		izen of What Co	10d. In	nside City Lîr	
MD TA Street and Number 7689 TRED AVON Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Lie	I CIRCLE 12. Was Decedent Armed Forces' 1 □ Yes 2 № If Yes, Give Year or Dates: Education grade completed)	t Ever in U.S. ? No	EASTO	N 10f. Zip	21	.601			10g. Citi		12		
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7689 TRED AVON Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Lie	12. Was Decedent Armed Forces' 1 Yes, Give Year or Dates: Education grade completed)	? No			21	601		ŀ	rog. Citi		ountry :		
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3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Li	If Yes, Give Year or Dates: Education grade completed)			U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2又 No Specify: WHTTF.									
15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Li	Education grade completed)			1 ☐ Yes	2 X No	Specif			Specify: WI	HITE			
(Specify only highest Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Li	grade completed)		16a. Deced	dent's Usua	al Occupa	ation	16b. Ki	ind of Business	/Industry	,			
12 Father's Name (First, Middle, La							ost of worki	ing	16b. Kind of Business/Industry				
Father's Name (First, Middle, La		5+)	ST	UDENT	,				STUDENT				
ROY BRIAND COM	est)			<u>OD BITT</u>		18. Mot	ther's Name	First, Middle	, Maiden				
TOT DICTION OO	DREY, JR.					\mathbf{D}_{I}	AEL FI	ERRIS					
a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a	and Num	ber or Rura	al Route Numb	er, City o	or Town, State,	Zîp Code	9)	
ROY B. COWDREY,	JR./FATHE	R	768	9 TRE	ZD AV	ON (CIRCL	E EASTO	N, M	ID 21601	L		
. Method of Disposition		000	ce of Dispo	sition (Nan	ne of	e)	С	Date	20c. Lc	ocation - City or	Town, S	State	
		⇒				1	CTR.1.	-24-200	5 ST	EVENSV	LLLE	, MD	
		GIIII	22	. Name an	d Addres	s of Fac	cility		-				
1-12/11 3	MAM	FUNERAI	_ HON	ME PA									
a. Part1. Enter the disease, or c	omplications that cause	ed the death.	Do not ent	er the mod	le of dying	g, such a	as cardiac o	or respiratory a	arrest,		App	roximate	
use. Enter Underlying use (Disease or injury tt initiated events sulting in death) Last													
d													
FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth	2 Fetal c	death 3							23d. Date of de Month	elivery Day	Year	
t II. Other significant condition	s contributing to death	ting in the u	nderlying c	ause give	en in Par	rt I.	23e. Did	23e. Did tobacco use contribute to the cause of deal			use of death		
								1 🗆	Yes 2	10 3 □ P	robably	4 Unkn	
								24a Was	200	24h Were a	utocsv fi	ndings avai	
								auto	psy /	prior to death?	completi	ion of cause	
								1 ☐ Yes	2 No			No	
. Was case referred to medical examiner?	Hospital:				Oth4	05:		74					
XXYes 2 No Manner of Death	1 inpat				JA	4					acity)	scen	
1 □Naturai 5 □ Pending	(Month, D	ay Year)	Injury		Work	k? .	1				~		
3 Suicide 6 □ Could no	ot be 380 Place of Is			2		.00 41		-				ite Number	
	building, e	etc. (Specify)			, omc o			City or To	wn, State	e) .		1	
a Cartifier					at the ti-	no data						LMOUN	
(Check only XX Medical E	xaminer: On the basis	of examination										cause(s)	
	and manner s	nateu.		290	c. License	e numbe			29d. Dat	te signed (Mon	th, Dav.	Year)	
S. Signature and title of certifier	11/10												
" removite	oneyhull					4.1 •			Jariu				
. Name and address of person w					C+	-	D-1.	d	M		0100	11	
1214 Suns				renn	otr	eet,	, Balt	more,	Mary	yland	Z120) <u>T</u>	
The state of the s	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe Signature of Funeral Service Li a. Part1. Enter the disease, or c shock, or heart failure. List of mediate Cause (Final ease or condition sulting in death) quentially list conditions, hy, leading to immediate size. Enter Underlying use (Disease or injury t infliated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown t II. Other significant condition t III. Other significant condition Was case referred to medical examiner? MXYes 2 No Manner of Death 1 Natural 5 Pending investiga 3 Suicide 6 Could no determin a. Certifier Check only one) D. Signature and title of certifier Name and address of person w Date filled (Month. Day, Year)	Signature of Funeral Service Licensee	Signature of Funeral Service Licensee	Cametery, crematery Cametery	Cemelary, crematory or Complete Chesapeake Chesapea	Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION	Cemelary, cramatory or other place	Suprature Supr	Cemetary, crematory or other place	Sunial 2 Cremation 3	Strain Committed of Committed Commit	Comparing Comp	

			For State Registrar	State of	Marylaı		artmen rtificat			ınd M	ental Hy	giene Reg. Né	000	5	031	487
	/sicia ledica		1. Decedent's Name <i>(First, Middle, Last)</i> Rita		Marie		Coupa	1			2. Date of De Month Januar	Day	, 200	у з аг)5	3. Time 2:45	
	amine		4a. Facility Name (If not institution, give 7216 Roanne Drive 5. Social Security Number 6. Se	!		. las <u>t</u> birthday)			Hill If Under 2		8. Date of Bin	Pr		Geo	rge's	
Fune Direc				_M 2⊠¥	r. Age (m yrs	84 _{Yrs.}	Months		Hours	Min.	06/27/	r920	1	Vew	Hamps	hire
he Maryland	office at	ector	10a. State 10b. County Maryland Prince Ge	orge's		ity, Town or Lo)xon Hi	11									City Limits
th with ti	del tree re	Funeral Director	10e. Street and Number 7216 Roanne Drive				10f. Zip	207	45			_	zen of WI USA	nat Coui	ntry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentel Hygiene. important: if Item 27 is marked other than "natural", or Itama 23s or 28s-1 show	EXAMENDE		11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Deced Armed For 1 Tyes X If Yes, Give Year or Da	ces?		Was Deced If Yes, spe-		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto	cify Yes or No Rican, etc.)			, White,	can Indian, etc. hite	
Z1Z15-UU36 Bd within 72 hours aff rgiene. er than "natural", or	The Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11		4or 5+)		dent's Usu: kind of wa DO NOT u Homen	rk done d se retired	ition luring most)	of worki	ng		nd of Bus		dustry	
Maryland 2121 d 2 should be filed within the and Mentel Hygiene. 27 is marked other than?	atic event,	To Be C	17. Father's Name (First, Middle, Last) Pierre Girouard								(First, Middle, la Lave		Surname)		
e, Mar 1 and 2 sho 1 eelth and 1 m 27 ie ma	ther traume		19a. Informant's Name/Relationship (7) Bryan J. Coupal / 20a. Method of Disposition		20h		0gelt	horp		eet	Riverda	ale,	Mary	1an		37
Baltimore, permit. Pages 1 a Department of Hee important: if item	njury or o		XXBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Suneral Service Licens	= =	and	cemetery, crer surrect	ion C	em.		1/27	/05	C1	intor	1, M	aryla	
permit. Departrimport	any ir		Vallika	elas !	h .						Kalas 1 Oxon H		ral H Mary	Home lan	d 207	45
Puysic /Medi Examii	cal ner	Examiner	23a. Party Enter the disease, o compishors, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	aDue to (c	zher	quence of):	. ,		ntia						Interval Be Onset and	atween
cate be executed bhysician and	ng eu	dicai		d	11 as a conse	quence on.										a
9 🗯 👼	detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown		th 2 ☐ Fetant at time of	al death 3 [Ectopic pi						23d. Date Mont		ery Day	Year
quires that	spould be delt	ed by P	Part II. Other significant conditions co.	ntributing to dea	ath but not re	sulting in the u	nderlying o	ause give	n in Part I.			obacco u res 2	_	rob	ne cause of pably 4	death?]Unknown
	page 2 sho	Completed						·····			24a. Was autop perfo	rmed?	pri	or to col ath?	psy finding mpletion of 2 No	available cause of
Of VITAL Physician: The This certificate	octor	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 □ In	patient 2	ER/Outpatien	t 3 🗆 DC	Othe			(Check only o		Other	(Specif	v)	
		ation: T	27. Manner of Death 1XXNatural 5 Pending 2 Accident investigation	28a. Date of (Month		28b. Time of Injury		8c. Injury Work		2	28d. Describe I				,,	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory	, office		2	28f. Location (5 City or Tox			or Rura	l Route Nu	nber.
Hospital 24 hours	iletely ti	edicai	29a. Certifier (Check only one) AC Certifying Phy 2 ■ Medical Exami	sicien: To the t ner: On the ba and mann	sis of examina	owledge, deatl ation and/or in	occurred vestigation	at the tim , in my op	e, date and inion, death	l place, a h occurre	and due to the ead at the time,	date and	and mani place, an	ner as st d due to	tated. the cause	(s)
To the To the	comp	Me	29b. Signature and title of certifier			mo		C. License		15		29d. Dat	e signed	Month,	Day, Year)	
Se			30. Name and address of person who co	ompleted cause	of death (Ite	m 23a) (Туре. 1Е	Print)	OF	rice	72va	d, N	ALD	ORF	N	D 20)60Z
Re	Stat		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature								•		

Patrick Michael Chase Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00437 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year PATRICK CHASE 18, 2005 4c. County of Death 03:15 P /Medical January 4a. Facility Name (If not institution, give street and number) 4h. Citv. Town, or Location of Death Examiner Chever 1 v

If Under 1 Year - If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
M & RCH 4 1984 Prince George's
9. Birthplace (State or Foreign Prince George's Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F 578 11 9973 20 Yrs. WASH. D.C. Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 27 is marked other than "naturel", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at FORESTVILLE P.G. MD. X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2722 LORRING DRIVE #101 20747 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHEF PVT. permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if item 27 is marked othe eny injury or other traumatic event, OMCB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLYDE CHASE SARAH WILLIAMS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLYDE CHASE/FATHER 2722 LORRING DR. #101 FORESTVILLE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MT CEM CLIVET CEM X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/05 WASH. D.C. *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licengee 22. Name and Address of Facility WATSON F. 3435 14th ST., N.W. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): ionact /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The faw requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗆 No 1X Yes 2 □ No 1X Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Inpatient 2 TREN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending investigation
6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated. 5 Pending Injury 1 Natural 2 Accident

Director:

Hospitel or Attending Physician: Certification: To 3 Suicide 4 ☐ Homicide within 24 hours a 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 0

State Registrar

2 OKL

29c. License number

29d. Date signed (Month, Day, Year)

OCME January 20, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2111 Penn Street, Baltimore, Maryland 21201 MONICA FOLLAK

JAN 2 5 2005

32. Pagistrar's Signature

Charles Campbell, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00472 State of Maryland / Department of Health and Mental Hygiene, crn For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 200^Y5^{ar} **Physician** January 20% 8:16 CAMPBELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours **Funeral** Davs Months 1⊠M 2□F 58 Director 578-58-0846 March 31 1946 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TxYes 2 □ No Director Landover Prince George's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 U.S.A. 2108 East Marshall Place Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 □ No Army If Yes, Give Year or Dates: 1 Never Married 2 Married Black. 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Police Officer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Steward Campbell Svlvester 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2108 East Marshall Place Landover, Maryland 20785 Gracie B. Campbell/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland Maryland Veteran's 2/1/05 * 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Si nalure of Funeral Pervice Licensee 7474 Landover Road Landover, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Cardiovascular Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The taw requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical as the use a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ó 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed certificate has Be 2

Hospital or Attanding Physician: 24 hours after death. Funaral Diractor; After this certifics Certification:

						1 X Yes 2 □	No 3 Probably 4 □Unknown
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ■ Yes 2□ No
25. Was case referred to medical				26	. Place of De	eath (Check only one)	
examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatient	3 DOA	Home 5 Residence 6	□Other (Specify)		
27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	280 M	injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury	occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	t, factory,	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,		
	ysician: To the best of my knowiner: On the basis of examinations and manner stated.						and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifier

abiullah

31. Date filed (Month, Day, Ye

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 21, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature

24 hours a

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		•	For State Registrar	State of N		/ Depa		t of H	ealth a		lental Hy	giene	_	034	90
			Hegistrar Decedent's Name (First, Middle, Last	*)			imout				2. Date of De	Reg. No. ath		3. Time of	Death
	Physicia	an	ALICE LISETTE	COLLIN-	DADTC						JANUAR'	J Day J 7	,2005		
7	/Medic		4a. Facility Name (If not institution, give				4h City	Town or	Location of	of Death	JANOAK		County of Dea		. •
	Examin	9	1100 LINDEN AVE	Street and manne	")				PARK) Douth			NTGOMET		
			5. Social Security Number 6. Se	x 7.	Age (In yrs. las	st birthday)	If Under		If Under	24 Hrs.	8. Date of Bir				r Foreian
	Funeral Director		081.44.1021	M 2 <u>M</u> F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov • 1	y, Year) 2, 19	920 Fr	inthplace (State of Country) S eetown, I	ierra eone
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside Cit	ty Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-f show ant, the Madical Examiner must be motified at	tor	Maryland Montgome	ry	Tak	coma I	Park							1 <u>;</u> Yes	2 🗆 No
	or 28	Director	10e. Street and Number				10f. Zip						zen of What C	Country?	
	23a	la	1100 Linden Aven					0912					S.A.		
	r deg	ne	11. Marital Status	 Was Decede Armed Force 	s?	. 13.	Was Deced If Yes, spec	ient of Hi ofly Cuba	spanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	. '	 Race - Am Black, Wh 		
36	s afte	Completed by Funeral	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 € If Yes, Give Year or Date			1 ☐ Yes	2X No	Specify:				Specify: B	lack	
8	hour ture	edt	15. Decedent's Ed			16a. Dece	dent's Usua	al Occupa	ation			16b. Kir	nd of Busines	s/industry	
15	in 72 an " n	plet	(Specify only highest grad	de completed)		(Give	kind of wo	rk done o	lurina mos	t of work	ing	Dent		,	
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b	be filed within 72 ho ital Hygiene. id other than "natur event, tre Modical	BeC	17. Father's Name (First, Middle, Last)								e (First, Middle,				
Maryland 21215-0036		10	Ernest Collin-P	aris					Ant	oine	tte Col	lín-	Paris		
lan			19a. Informant's Name/Relationship (7				•	•			al Route Numb	_			
≥,	1 and Health tem 27 other tra		Donald Peters/Sor	1										land SN1	3AE
ore	of H		20a. Method of Disposition 1 Burial 2 梵 Cremation 3 日	Removal from Sta	20b. Pla cer	netery, cre	osition (Nar matory or o	ne of ther plac	Θ)		Date		cation - City o		
ţi	tant:		*4 □ Donation 5 □ Other (Specify)	Fort						21/05	Bren	twood,	Maryla	aa
Baltimore,	permit. Pages 1 am Department of Healt Important: If item 2 any injury ocother once.		21. Signature of Funeral Service Licen	Vercon	tie	H	1800 N	RINA Jew 1	LDI F Hamps	UNEF hire	AL HOMI	ilve.	NC. r Spri	ng.MD 20)904
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cau	sed the death.	Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Bet	e ween
1	Physician		Immediate Cause (Final disease or condition	A							wm		nse	Onset and (Death
	/Medical		resulting in death)		as a conseque						CC- II-	در. ب	127		1
	Examiner	_	Sequentially list conditions,	b											
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Utila to (or	яв в попведне	entra-ory:									
	ate be executed nysician and he burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):									
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687	icate phys s the			d											
Box (certif nding use a	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnan		_					2	23d. Date of d	elivery	
ă	death a attei	iciai	in the past 12 months?	4□Pregnan	n 2 ∏ Fetalo tattime of dea		⊒Ectopic pi ⊒ Other (sp						Month	Day	Year
O.	that the death certificate ed by the attending phys detached for use as the	Physician/Med	9 Unknown	9□Unknow	n										
S,	The law requires that the death certificate be executed at the seen signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions of	ontributing to deat	h but not resul	ting in the u	underlying o	ause give	en in Part I		1		1/	to the cause of d	
ord	w requir been si should	ted									1 🗆	Yes 21	_ M o 3 □ I	Probably 4 🗍	JIKHOWA
Records,	e 2 sh	Completed									24a. Was		24b. Were a	autopsy findings a completion of ca	available ause of
al F	sicien: The law certificate has b irector, page 2 s											2 No	TO Ye	es 2 No	
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of	Phys this ral dir	. To	1 🐧 Yes 2 □ No 27. Manner of Death	1 ☐ Inp		R/Outpatie	_	28c. Injun	4 🗆 140	ursing Ho	me 5 ☐ Resi 28d. Describe			pecify SCENE	
U	ding F h. After funer	tion	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	М	Worl	k? Yes 2□	No			,		
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	1	For State Registrar		epartment of Health and Certificate of Death		ne No.2005	0349	
Physicial /Medica Examine	n il	4a. Facility Name (If not institution, give	a T. Caplinger	4b. City, Town, or Location of Dea	January 2	Day Year 21 2005 4c. County of Death	3. Time of Death 1:00 P	
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	ል	1 Never Married 2 XMarried 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify: Decedent's Usual Occupation Sive kind of work done during most of w	166	Black, White,	nite	
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permit. Pages 1 ar Department of Hea Important: If Item eny injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specifi	Removal from State 20b. Place of Commetery, Crest	Disposition (Name of crematory or other place) Lawn Mem. Gard, 1-2	Date 2005 5-2005 Ma	E. Location - City or To	wn, State Lle, Md	
perimi Depa Impo eny ii		21. Signature of Funeral Service Licer Collina 23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do no	22. Name and Address of Facility Ha 4112 Old Columbia t enter the mode of dying, such as cardi	Pike Ellic	ott City,	MD 21043 Approximate Interval Between	
hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a consequence of)):		2	Onset and Death	
ysicia	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of) Due to (or as a consequence of) d.					
by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ory Day Year	
igne bed	þ	Part II. Other significant conditions of	ontributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobace 1 ☐ Yes	co use contribute to th	ne cause of death? ably 4 DUnknow	
	e Completed	25. Was case referred to medical		28 Place of D	24a. Was an autopsy performed 1 Yes 2 1	prior to condeath?	psy findings available inpletion of cause of 2 No	
this aldi	ation: To Be	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir Injury	nation 3 DOA Other: 4 Nursing	Home 5 Residence 28d. Describe how i		v)	
pital or Attendi	l Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S			
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check only one) 29b. Signatur and littly certifier	ysician: To the best of my knowledge, niner: On the basis of examination and/ and manner stated.	opean occurred at the time, date and plat or investigation, in my opinion, death occurred 29c. License number	curred at the time, date	and place, and due to Date signed (Month,	the cause(s) Day, Year)	
2 A		30. Name and address of person tho	completed cause of death (Item 23a) (T	1)005 8 (3) ype, Print) S+307	tmister	January 24	W - 10	

DHMH 17 Rev 1/2001

ORIGINAL

		1	For	Department of Health and I Certificate of Death	Mental Hygier	2111122 03103
	_		Decedent's Name (First, Middle, Last)	0	2. Date of Death	3. Time of Death
	Physicia /Medic		Paul Sien-Viet	Cao	JANUALY	23 2005 1044 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	None 9. Birthplace (State or Foreign
	Funerat Director			Yrs. 4 28 Hours Min.	(Month, Day, Yea	on Maryland
	g.		Usual Residence of Decedent		11.09 207 2	
	arylar show	_	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2☑ No
	he M.	Director	MD Howard Columb	Oia 10f. Zip Code	100	Citizen of What Country?
	with t	Ö	10250 Hickory Ridge Road #202	21.044		ited States
	death ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian,
9	after or ite	Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 Yes, Give	1 ☐ Yes 2 ☑ No Specify:	o rican, etc.)	Black, White, etc. Specify:
93	hours after death with the Maryland turel', or Items 23a or 28a-f show al Exammer must be motified at	d by	3 Widowed 4 Divorced Year or Dates:		105	Asian Kind of Business/Industry
15-	in 72	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	, Kind of Businessandustry
212	e filed within at Hygiene. othar then " vent, the Wel	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	N/A		N/A
ng	be filed tal Hygir d othar event, L	BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Sumame)
Maryland 21215-0036	2 should be and Mental is marked o aumatic eve	ှင	Steve T. Cao	Ha T. N		To Chata To Conta
Mar	d 2 sh th and 7 is m traum		,	. Mailing Address <i>(Street and Number</i> o <i>r Ru</i> 0250 Hickory Ridge R		
-	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygene. I Health and Mental Hygene. I fire 12 is marked othar then "neturel", or tlems 23a or 28a-f show then 21 is marked othar then "neturel", or tlems 23a or 28a-f show other traumatic event, the Medical Example most be notified at	- 8	20a Method of Disposition 20b. Place of	t Disposition (Name of ry, crematory or other place)		Location - City or Town, State
m 0			1 Burial 2 Ocemation 3 Hemoval from State		-2005 Ca	tonsville, MD
Baltimore	permit. Page Depintment of Important: If any injury or once.		21. Signature of Funeral Service Licensee			ke's Family FH Inc.
<u>m</u>	89729		Den Collins-Algh	4112 Old Columbia		
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	i	Immediate Cause (Final disease or condition resulting in death)			3 WEEKS
	Examiner		Due to (or as a consequence		Tues	2 Marson
	IPS N	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		LAVIECTION	2. 110/01113
	be executed sician and burial-transit	Examin	that initiated events c. SXTREME	PREMATURITY		5 MONTHS
30,	oe exe		resulting in death) Last Due to (or as a consequence	of):		
9289	the the	dical	d			
ox 6	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
B.	death e atte	iclai	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	that the de ed by the detached	hys	9 ☐ Unknown		00 Bidah	
	ires tha signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobaco	2 Ano 3 Probably 4 Dunknown
orc	w requir been s should	eted			24a. Was an	
Records,	has b	Completed			autopsy performed	
Vital		ပိ	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 xth (Check only one)	No 1 ☐ Yes 2 No
>	Physicien: this certificanal director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	Other		6 □Other (Specify)
n of			27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b.	Time of 28c. Injury at Work?	28d. Describe how in	njury occurred
Sio	death. ctor: A y the fu	catle	2 Accident investigation	M 1 Yes 2 No	29f Location /Street	and Number or Dumi Pouts Number
Division	or Attendated after death Director: ,	Certification:	3 Suicide Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	City or Town, St	and Number or Rural Route Number, rate)
_	spital		29a. Certifier Certifying Physician: To the best of my knowledge			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.			
	To the comp	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Conne-Kise J. Ychay MD	6467922	7 1	INVARY 23, 2005
2			30. Name and address of person who obmpleted cause of death (Item 23a)	(Type, Print) DE, GARTMENT OF	NEVINATOLOKY	NEWS V Secondfloor
	Sta	ate	31. Date filed (Month, Day, Year) 32. Projectar's Signature	Unino migras pridital 600	NOTIN WHERE	T. Dalamore MD = 1287
	Regist	rar	29b. Signature and title of certifier Ame - Mse	Sperie		

			1 = For State Registrar	State of Maryland		artment of H tificate of L		_	iene	05 0010	
4 19	Physic		Decedent's Name (First, Middle, Last) Alfred Joseph C	lote Jr.				2. Date of Deat Month Jan 18,	Day	Year 10:10 A ^h	
10000000000000000000000000000000000000	/Medi Examir		4a. Facility Name (If not institution, give si Lorien Nursing			4b. City, Town, or Columb			4c. County o	of Death	
	Funeral Director		5. Social Security Number 6. Sex 218-24-7051 Usual Residence of Decedent	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year)	9. Birthplace (State or Foreig Rhode Island	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Maryland a-f show	tor	10a. State 10b. County MD Howard	10c. City, 1						10d. Inside City Limits 1 ☐ Yes 2 💆 No	
	3a or 28	I Director	10e. Street and Number 12937 Kentbury Di	rive		10f. Zip Code 2102	:9		10g. Citizen of What Country? Inited States		
	urs after deatl al', or Itams 2 Examiner ou	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Black	- American Indian, c, White, etc. White	
1215-0	within 72 hou ene. than "nature the Moulcal E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lent's Usual Occupa kind of work done of DO NOT use retired, rical Enc	luring most of w)	vorking	16b. Kind of Bus	Business/Industry		
yland 2	ould be filed Mental Hygi harked other	To Be Co	17. Father's Name (First, Middle, Last) Alfred Joseph	Cote		18. Mother's N Margar	ame (First, Middle, M				
Baltimore, Maryland 21215-0036	es 1 and 2 sh of Health and fitem 27 is m ir other traum		19a. Informant's Name/Relationship (Type Elsie R. Cote/ With 20a. Method of Disposition 1 □ Burial 25 Cremation 3 □ Re	fe 20b. Plac	12937 e of Dispo	g Address (Street a Kentbury sition (Name of natory or other place	Drive	Rural Route Number Clarksvi Date	lle, MD		
Baltim	permit. Pag Department Important: I eny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Metro	s of FacilityHa	The second second		Family F.H., I			
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Our ICIN Con Dementic									Approximate Interval Between Onset and Death		
8760,	cate be executed by physician and burial-transit and	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen							
O. Box 6	death certif e attending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deatl 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)				of delivery th Day Year	
s, P.	wrequires that the death been signed by the atte should be detached for	ed by Ph	Part II. Other significant conditions confi			use contribute to the cause of death?					
Division of Vital Record	The lar	Completed						24a. Was ar autops perforn 1 \super Yes 2	psy prior to completion of cause of death?		
n of Vit	ng Physician: After this certifica	on: To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28	Outpatien Time of Injury	Othe	at Mursing		one esidence 6 □Other (Specify) be how injury occurred		
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	, farm, stre	M 1 ☐ Y	′es 2 □ No		ion (Street and Number or Rural Route Number, r Town, State)			
	he Hospital n 24 hours a he Funeral (edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	use(s) and manr te and place, an	ner as stated. nd due to the cause(s)	
ţ	To the within 2 To the complet	Me	29b. Signature and title of certifier	MD		29c. License	number		1	(Month, Day, Year)	
6			30. Name and address of person who cor	3060 mi.	tchell		Bo	wie m:) 20	716	
	Sta Regist	10	31. Date filed (Month, Day, Year)	32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month 2005 Physician žž, Dorothy May Loder Colvard М January 0135 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace Harford Harford Memorial Hospital 8. Date of Birth (Month, Day, Year) 8, 1923 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F 81 186-16-7774 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1⊠Yes 2□No Perryville Directo Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 430 Harford Street 21903 U.S.A. items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after ☐Yes 2 X No Yes. Give 1 □ Never Married 2 □ Married ö 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Harford Memorial Hospital d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Two Years Elementary/Secondary (0-12) Havre de Grace, Maryland Licensed Practical Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Loder Dorothy unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s Health an Sherry Rogers (Daughter) 87 St. Mark's Church Road, Perryville, MD 21903 other Hem 20b. Place of Disposition (Name of cemetery, crematory or other place) Importent: If ite eny injury or oth once. Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 Burial 2 □ Cremation 3 □ Removal from State Hopewell Cemetery 01/27/05 Port Deposit, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Son Funeral Ho Land 21903-0766 Lee A. Patterson Home. CHLEVADY, SV. Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 200 No 2 \\No 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 💢 ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 \ Homicide 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, S. CRIEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 2 5 2005

Baltimore, Maryland 21215-0036

Box 68760,

Vital Records, P.O.

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death a005 Month O/ **Physician** Sr. 29 1:00PM Anderson Cross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Villa Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year Dec 26, 1910 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MD 1 ☑ M 2 □ F 214-05-6275 94 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23e or 28e-f show the Medical Examinar must be notified at MD Allegany Cumberland 1 Xes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Baltimore Street 21502 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Item any injury or other traumatic event, the Medical Examerations. Black, White, etc. 1 Never Married 2 Married 1XYes 2 No IfYes, Give Year or Dates: WWII 1 Tes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Allegany Ballistics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bashor Anderson Cross Mary Jane Taylor Cross Shipley 19a. Informant's Name/Relationship (Type, Print)
Ronald Cross 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 14804 McGill Drive SW Cumberland MD 21502 son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Sunset Memorial Park 2/2/2005 MD Cumberland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee 22. Namscarpenis Punellal Home, P.A. ▶ 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Myocardial Syarction Pnysician disease or condition resulting in death) unnte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chronic Kenalinsuffice Myelodysplast C Syndrowe 2No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2000No 1 Yes Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 26 No Other: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Uursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pendina after death.

Director: Aff
in by the fur 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46346 MI) 2-1-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Suite 304 Cumberland MD 21502 Huma Shakil M.D. 7 2005 3 Registrar's Signature 31. Date filed (Month) Day State Registrar

an al	7 30-41-41 1/1/4 4 13/21-4							ear _ /		
	IRVIN OSCAR DRUM		SR.			Januar		05 1004 "		
er	4a. Facility Name (If not institution, give street and not		/	4b. City, Town, or	Location of Death		14c. County of I	4		
	1 he Memonial 1to		(ast birthday)	If Under 1 Year	TO N If Under 24 Hrs.	8. Date of Birth		007 Birtholaca /State or Foreign		
	√X M 2□ E		Yrs.	Months Days	Hours Min.	(Month, Day NOV 28	1920	Birthplace (State or Foreigr Country) MARYLAND		
	Usual Residence of Decedent					110				
	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
cto	MD CAROLINE		PREST	ON				1 ☐ Yes 2 No		
Dire	10e. Street and Number			10f. Zip Code		1		•		
ral			0 100							
nue	Armed F	orces?	.S. 13. V	was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, V	Amencan Indian, White, etc.		
	1 Never married 2 Married If Yes, G 3 □ Widowed 4 □ Divorced Year or	ive Dates:	1	I□Yes 2∭Q No	Specify:		Specify:	WHITE		
	15. Decedent's Education		16a. Deced	ient's Usual Occup	ation		16b. Kind of Busin	ess/Industry		
plet			(Give	kind of work done o OO NOT use retired	during most of work i)	ing		,		
E O	12 0	(1-401 5+)	EX	ECUTIVE			CON	STRUCTION		
a	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	-		
	OSCAR M. DRUMMER			_	MAR	RIE LYNCH				
	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	al Route Numbe	r, City or Town, Sta	ite, Zip Code)		
	IRENE EVANS DRUMMER/WII						TON, MD	21655		
	20a. Method of Disposition		lace of Dispo emetery, cren	sition (Name of natory or other plac		Date	20c. Location - Cit	y or Town, State		
	' 4 □ Donation 5 □ Other (Specify)		ESTERF	IELD CEM	1-3	1-2005	CENTREVI	LLE, MD		
	21. Signature of Funeral Service Licensee	-				N & NEUN	IAM EIINED	AT HOME DA		
1	JOHN R MER	CERS		OO S. HAF	RISON ST	EASTON,	MD 2160	l HOME FA		
	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
i u	Immediate Cause (Final disease or condition	ible s	epos	rend	my n	try to	riline	Onset and Death		
	resulting in death) Due to	(or as a conseq	nce of):	. , , ,	0	0				
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lne	if any, leading to immediate cause. Enter Underlying	o (or as a consequ	uence of):		+		W/	Weeks		
хап	that initiated events	(or as a consequ	resta	umer			TICAL EXAMINER	viens		
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_	d				The second	N POOKO.				
√Me					4		23d. Date o	f delivery		
clar	in the past 12 months?						Month	Day Year		
lys	9 Unknown 9 Unk	nown								
						23e. Did to	bacco use contribu	ite to the cause of death?		
d b	Covariary artery a	therose	krosi	is SIP C	ABG	1 🗆 Y	es 2 1 1No 3[☐ Probably 4 ☐Unknown		
lete	Arterio scherotic nent	valele	rosis	·			an 24b. Wer	e autopsy findings available		
duc	Recorded		V V V V			perfor	med? deal			
	25. Was case referred to medical				26 Place of Deat			Yes 2□ No		
00	examiner?	Inpatient 2	EB/Outnatien	3 DOA Oth				(Specify)		
-			28b. Time of					<i>арвану)</i>		
ig ig					k? Yes X □No	Subject	fell			
fica	- C Could got be					28f. Location (S	treet and Number of	or Rural Route Number.		
ert	Stre	et outsi	de Cha	ince's St	ore			Preston MD		
	29a. Certifier 1 Certifying Physician: To the	ne best of my kno	wledge, death	occurred at the tin	ne, date and place,	and due to the c	ause(s) and manne	er as stated.		
adic		basis of examination of the state of the sta	tion and/or inv	estigation, in my o	pinion, death occur	red at the time, d	late and place, and	due to the cause(s)		
Ž	29b. Signature and title of certifier) , ,		29c. Licens	e number	2	29d. Date signed (A	Month, Day, Year)		
	Preminant O. Ja	hmel	nes	D34	633		1-25-	2005		
	30. Name and address of person who completed can	use of death (Item	n 23a) (Type,							
		101	1 M.	N						
	Reinhardt O.	lahme	701.	<u>り・219</u>	S. WASHI	NGTON ST	., EASTO	N, MD 21601		
ite ar		Rystrar's Signa		D · 219	S. WASHI	NGTON ST	., EASTO	N, MD 21601		
	o Be Completed by Physician/Medical Examiner	Social Security Number 214-12-6278 Usual Residence of Decedent 10a. State 10b. County MD CAROLINE 10e. Street and Number 21719 DOVER BRIDGE RD. 11. Marital Status 12. Was December 15. Decedent's Education Specify only highest grade completed Society only highest	S. Social Security Number 214-12-6278 Sax 7. Age (In yrs.	S. Social Security Number 214-12-6278 84 7/s.	S. Social Security Number 2.14-12-6278 S. M. 2 F. 7/Age (In yrs. last birthday) H. Under 1 Year 2.14-12-6278 S. M. 2 F. 7/Age (In yrs. last birthday) H. Under 1 Year 2.14-12-6278 S. M. 2 F. 7/Age (In yrs. last birthday) H. Under 1 Year 2.14-12-6278 S. M. 2 F. 7/Age (In yrs. last birthday) H. Under 1 Year 2.14-12-6278 S. M. 2 F. 7/Age (In yrs. last birthday) H. Under 1 Year 3.15 S. M. Social Search of the International PRESTON S. Carolina	Social Security Number 214-12-6278 Usual Residence of Decedent Usual Residence of Decedent 10. State 10b. County 10c. City, Town or Location PRESTON 10c. Street and Number 21719 DOVER BRIDGE RD. 12 Was Decedent Ever in U.S. 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp. 14 Yes, 20 No. Specify. 15 Decedent's Education 15 Decedent's Education 16 Specify only highest grade completed) 16 Decedent's Education 17 Specify only highest grade completed 18 Informant's Name Reliationship (Type, Print) 19 Informant's Name Reliation	Social Security Number 214-12-6278 Ususi Residence of Decedent Ususi Residence of Decedent 10c. Clay, Town or Location MD CAROLINE PRESTON 10c. Clay, Town or Location PRESTON 10c. Street and Number 21719 DOVER BRIDGE RD. 11. Marital Status 12. Was Depotent Firer in U.S. \$\frac{1}{2}\text{Vers}\$ \frac{1}{2}\text{Vers}\$ \frac{1}	Social Sectify Number Social Section Social Section		

Arthur R. Deem 05-0642 ALG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylai	nd / Depa		of He	alth and	-	rgiene Reg. No	0.5	03498
Physic /Med	lical	Decedent's Name (First, Middle, Last) Arthur Aa. Facility Name (If not institution, give a	Rodney De				ocation of D	2. Date of De Month Januar	y 26, 2	OO5	3. Time of Death 5:15 A M
Exam Funera Directo	1	Garrett County E	ospital	. last birthday) Yrs.	Oak1	1 Year	If Under 24 Hours N	lin. (Month, D			place (State or Foreign ntry) ryland
D D		Usual Residence of Decedent 10a. State 10b. County MD Garr	10c. C	ity, Town or Lo	De	er Pa	ırk				10d. Inside City Limits 1⊠ Yes 2 ☐ No
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Marical Examples must be notified at	Funeral Director	10e. Street and Number 79 Oak Street 11. Marital Status 1 □ Never Married 2 ♣ Married	12. Was Decedent Ever in t Armed Forces? 1 □ Yes 2 점 No	J.S. 13.	Was Deced	21	550 Danic Origin? Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Bla	SA ce - Americ ack, White,	can Indian, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. P7 is marked other than "natural", or traumatic event, the Neulcul Explic	Completed by F	3 Widowed 4 Divorced 1 15. Decedent's Edu (Specify only highest grade	If Yes, Give Year or Dates: s Education		dent's Usua kind of word DO NOT us	l Occupati		working	16b. Kind of E	Specify: White Sb. Kind of Business/Industry	
yland 2121 buld be filed within Mental Hygiene. arked other than	To Be Com	10th 17. Father's Name (First, Middle, Last) James Art		eem	Maint		e Man 8. Mother's Ruth	Name (First, Middle The		otel _{me)} Frie	nd
re, Maryla s 1 and 2 should f Health and Men ltem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Margaret Deem/Wif 20a. Method of Disposition	e 20b.		ak St	reet,		Park, Ma	-	21550	
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or other	XIIX	1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	De	er Parl	k Ceme 2. Name and	tery d Address	of Facility	'29/05 Home	Deer E 32 S. Oaklan	Secon	
Pnysiciar /Medica	1	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deane cause on each line. a. Due to (or as a conse	ath. Do not en	ter the mode	of dying,	such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
3760, are be executed EX nysician and III he burial-transit e	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse								
O. Box 68. The death certific The death cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3[⊒Ectopic pre					ate of delive	ery Day Year
Cords, P. wrequires that been signed by should be deta	ğ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	underlying ca	ause given	in Part I.		Yes 2□No	3 Prob	
	e Completed	25. Was case referred to medical					26. Place of	24a. Wa: auto perf 1 X Yes Death (Check only	opsy ormed? 2 \(\text{No} \)	Were auto prior to co death? 12 Yes	psy findings available mpletion of cause of 2 No
ion of nding Physath. r: After this e funeral di	ation: To B	examiner? 1	Hospital: 1 Inpatient 25 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		8c. Injury a Work?	4 🗀 (40) 5()	g Home 5 Res 28d. Describe	idence 6 Ot how injury occu		ýy)
i gitte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec					28f. Location (Street and Number or Rural Ro City or Town, State)			
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 25 Medicel Exami 29b. Signature and title of certifier	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deal nation and/or ir	nvestigation,	in my opir	nion, death o	ace, and due to the	date and place, 29d. Date signe	, and due to	o the cause(s)
T W V O		> Zalvisu	LUS A	- C -		C.M.I	Ξ.		Januar		
	State	30. Name and address of person who co		4	111		Stree	t, Baltin	ore,Mar	y1and	21201
Regis		JAN 2 8	ZUUJ Magas	Le B	Acon	12.					

. '	•	-	For State	State of Maryland /		rtment of H			71101	5 02100			
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate or t	Jean	2. Date of Deat	Reg. No. C. U J				
	Physicia	_		Gladys Cathe		Month	Day Year	0 F F 00 7 M					
	/Medic	al -	4a. Facility Name (If not institution, give s		Line	4b. City, Town, or	Location of Deal	Januar	y 31, 20 4c. County of Dea	05 5:00P			
	Examin	er	10440 Church Hi			Myers			Frede				
_	Funeral		5. Social Security Number 6. Sex		birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		thplace (State or Foreign			
	Funeral Director	1]м 2) ДF	Yrs.	Months Days	Hours Min.	Februa	ry 12, Ne	W Jersev			
	D		Usual Residence of Decedent					-	<u> </u>	10d. Inside City Limits			
	ahow	_	10a. State 10b. County	10c. City, To	OWN OF LO					1 Tes 2 No			
	8e-f	cto	MD Frederi	ck		Myersvi	<u> 11e </u>	1	0g. Citizen of What C	ountry?			
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code							
	s 23e	ra	10440 Church Hi	11 ROAC 12. Was Decedent Ever in U.S.	13 V	217		Specify Yes or No-	U.S.A 14. Race - Am				
	er de Item	Ĕ.	11. Marital Status 1 Never Married Married	Armed Forces? 1 Yes 2 XNo			n, Mexican, Puer	Specify Yes or No- to Rican, etc.)					
99	urs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 X No	Specify:		Specify: W	hite			
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. do ther than "natural", or ttems 23a or 28e-f show event, the Medical Evantiaer must be notified at	te d	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working							/industry			
뚪	hin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use retired)						
7	ad wit	9	12			Actuary		(F)	Insuran	ce			
힏	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,					
yla	should be I and Mental I s marked o umatic eve	ဥ	Walter Walke					1 Rhode					
Maryland	permit. Pages 1 and 2 should by Obspartment of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Ty						rsville,				
			Francis Ralph E	20b. Place	e of Dispo	sition (Name of			20c. Location - City of				
Baltimore,	in ite		1 ☐ Burial 2 🏋 Cremation 3 ☐ F	lemoval from State Smi	thsb	natory or other place U.Y.G	IFCO	ruary s	mithsbur	g,Maryland			
Ē	it. Pa		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		matc	Name and Address	The state of the s	2005	vis Fune				
Ba	permi Depa Impo any i		Tour 1	I wis male						,MD 21783			
			23a. Part1. Enter the disease, or comp	ications that caused the death.						Approximate Interval Between			
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.						Onset and Death			
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or a consequen	nce of):	Hart I	hseese-						
	Examiner			b									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	cuted nd ransi	Examiner	tuat initiated evenitz	c	-		400						
ó,	te be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a consequen	ice or):								
8760,	icate be executed physician and s the burial-transit	dicai	•	d									
9	death certifica e attending ph d for use as It	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy	v				23d. Date of de	alivery			
Вох	attend for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3	Ectopic pregnancy Other (specify)	<u> </u>		Month	Day Year			
o.	at the de by the	ysic	1 □ Yes 2. No 9 □ Unknown	9□ Unknown									
Q	de ed		Part II. Other significant conditions co	ntributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
Records,	puires n sign	d by						1 🗆 Y	′es 2.XNo 3.∏F	robably 4 Unknown			
õ	w requir been si should	Completed						24a. Was a		autopsy findings available completion of cause of			
Be	The lav	E C						perfor	rmed? death?				
Vital		O	25. Was case referred to medical				26. Place of De	eath (Check only of					
	dis Y	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	NOutpatier	it 3□ DOA Oth	er: 4 Nursing	Home 5 Resid	ience 6 □Other (Sp	ecify)			
n of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	Wo		28d. Describe h	now injury occurred				
Sio	Attending of death. ector: After by the fune	catic	2 Accident investigation				Yes 2 □No	20f Location /6	Street and Number or I	Rural Boute Number			
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, sti	eet, factory, office		City or Tow		ibiai i tobio i tombor,			
	Hospital of thomes all Funerel E		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	edge deat	h occurred at the ti	me, date and pla	ce, and due to the	cause(s) and manner	as stated.			
	Hos 24 ho Fun Fun	edical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	n and/or in	vestigation, in my	pinion, death oc	curred at the time,	date and place, and du	ue to the cause(s)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier			29c. Licens	e number	<u> </u>	29d. Date signed (Mor	nth. Day, Year)			
	⊢≯⊬ŏ		> man	MO		77044	56701		2-2-	95			
	X		30. Name and address of person who o	completed cause of death (Item 2	За) (Туре,	Print)	0/40	sille mo	4 - 4				
	4		V () 1	larren 3000 - 7	D Va	trie ct.	Mycrs	rille MD	21773				
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signatur	re	M. a	•						
	Regist	rar	FEB 0 7 2005	Marker 10.	15/00	23							

			1 - For State Registrar	State of M	larylan		artmen rtificate			and M		giene	005	035	00																		
	Physicia	an	1. Decedent's Name (First, Middle, Las Albert R. Else								2. Date of Dea	Day	Year	3. Time of																			
	/Medic	al		sser	-1		41- 01-	Tana -	1		January		2005 County of Deat	4:10	P M																		
	Examin	er	4a. Facility Name (If not institution, give Shady Grove adven				46. City,		Location o				Mont gor																				
	Funeral		Social Security Number 6. S	9X 7. A		ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h.	0.0:4	hplace (State o	or Foreign																		
	Director		170-03-4163	X M 2□F	90	Yrs.	Months	Days	Hours	Min.	(Month, Da	24,1	914 PA	A																			
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation	-						10d. Inside C	ity Limits																		
	f sho	JO.	MD Montgo	merv			singto	. n							2 🗆 No																		
	r 28a-	rec	10e. Street and Number	mery	1	ROIL	10f. Zip					10g. Citiz	en of What Co	untry?																			
	th with	ai D	3616 Littledale	Road				:	20895			Unit	ed Stat	es																			
	r dea tams	ner	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	. 1	4. Race - Ame Black, White																				
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XiYes 2 ☐ If Yes, Give Year or Dates:	TITIT		1 ☐ Yes 2	No 🍇	Specify:				Specify:	White																			
21215-0036	be filed within 72 hours after death with the Maryland ale Hyglene. And other than "natural", or flams 23a or 28a-f show other than "natural", or flams 23a or 28a-f show event. It a Madical Examiner main be notified at	ted t	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	I Occupa	ition			16b. Kin	d of Business/	Industry																			
215	within 7: ene. than "n	Completed	(Specify only highest gra	de compteted) Cotlege (1-4or	life. [kind of work done during most of working DO NOT use retired)			ng	,																					
	filed with Hyglene. Ither ther	Con		4		Engineer							Engineering																				
and	butd be fil Mental H arkad otl atic evan	Be	17. Father's Name (First, Middle, Last) Lawrence Elsesse	r			18. Mother's Name				ude Wag																						
Maryland	shoutd nd Me mark matic	၉	19a. Informant's Name/Relationship (1	ype, Print)		19b. Mailir	ng Address	(Street a			I Route Numbe		Town, State, 2	Zip Code)																			
M	nd 2 is 27 is r trau		Kathryn Lynch	/ Daught	er	17803	Bria	rdal	le Ro	ad,	Derwood	, MD	20855																				
ore,	ritam of Hee		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Damoual from State		lace of Dispo	natory or or	ther place	9)		ate	20c. Loc	ation - City or	Town, State																			
ij	Pag ment ant: h		`4 □ Donation 5 □ Other (Specify		Met	ropeli	mator	У	į.	2008	ary 22		exandri																				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is merked any injury or other traumatic evonce.		21. Signature of Funeral Service Licen	\$66 (A)		22 F	ark D	d Addres rive	s of Facilit	yDeVo ithe	ol Fune rsburg,	ral H MD 2	Home, 1 20877	0 East	Deer																		
Е			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the death line.						r respiratory ar	rest,		Approximat Interval Bet Onset and I	ween																		
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): PNEUMONIA																														
	P	jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	ience of):	10 6 () / ~ (0 10	- / (
	ate be executed hysician and the burial-transit	Examine	Cause, Enter Underlying Cause (Disease or injury that initiated events c																														
, 0,	e exe clan al urial-t	EX	resulting in death) Last	Due to (or a	s a consequ	uence of):																											
8760,	physic physic the b	dica		d																													
9 X	eath certific ettending p	/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ncy						2:	3d. Date of deli	verv																			
O. Box	The law requires that the death certificate be executed the has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit							by Physician	y Physician/Medical		ysiciar	ysiciar	ysiciar	nysiciar	ysiciar	ysiciar	ysician	ysician	ysician	ysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown			Ectopic pro Other (sp						Month	,	Year
ď.	igned by										Part II. Other significant conditions of	ontributing to death	but not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of d	leath?										
ords	w require been sig should b								 .		1 🗆 Y	es 2	No 3□Pr	obably 4 □l	Jnknown																		
Vital Records,	The law rate has be page 2 sh	Completed											prior to death?	topsy findings completion of c	available ause of																		
/ita	Physician: The this certificate ral director, page	Be (25. Was case referred to medical examiner?					0.1		of Death	(Check only o	ne)																					
of	Physic this or	To .	1 Yes 2 No	Hospital:		ER/Outpatien		-	4 🗆 140		ne 5 Resid			cify)																			
	ding h. After fune	27. Manner of Death 1																															
Division	i or Attending after death. Diractor: After J in by the fune	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 9 28a. Date of Injury 28b. Time of Injury Work? M 1 Yes 2 No 28b. Time of Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurre 28d. Describe how inju									Number or Ru	ral Route Num	ber,																				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											:)																			
	To th within To th comp	Me	29b. Signature and title of certifier		2	,),	29c		number				signed (Month																				
10	140			my	Ze_	10	10	Do	005	7	129	(/:	22/0	5																			
J.	0-11		30. Name and address of person who a Truong Boa, M.D.					rrac	e, Ge	rman	town ,	MD 2	0874																				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 200	27	trar's Signat	ture for	de la																										